

Guide to

Risk Factor and Outcome Instruments

*for Youth Substance Abuse
Prevention Program Evaluations*



DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention

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The Implementation Guide series is designed to assist practitioners in implementing research- and evaluation-based prevention strategies to advance community-based prevention. This Implementation Guide was developed under the direction of the Division of State Prevention systems, Gale Held, M.P.A., Director; Beverlie Fallik, Ph.D., Project Officer.

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Foreword

The Substance Abuse and Mental Health Service Administration's (SAMHSA's) Center for Substance Abuse Prevention (CSAP) is the Federal agency charged with improving the quality and availability of the Nation's substance abuse prevention services. SAMHSA/CSAP sponsors a wide range of national prevention activities, including information dissemination, training and technical assistance, community demonstration programming, and special projects in multiple areas critical to the prevention field. These activities complement other Federal, State, Territorial, tribal, local government, and other community and organizational initiatives to produce a complex set of prevention strategies and programs—each directed at tackling one or several of the interconnected societal problems related to substance abuse.

SAMHSA/CSAP is committed to helping States and communities evaluate their existing programs with a view toward refining them to achieve maximum reductions in substance abuse and its related problems. The U.S. Department of Health and Human Services has chosen to focus attention and dedicate considerable effort to substance abuse prevention among youth through the Secretary's Youth Substance Abuse Prevention Initiative. This document blends these two significant themes.

The Need for Careful Program Evaluation

In this era when citizens hold public programs strictly accountable for monies spent, prevention practitioners need to demonstrate that their work is effective. Program evaluation will yield the most useful data, and the most convincing results, when scientifically based methods are used. Program evaluators must choose instruments that have been shown to measure what their prevention strategy is designed to change. Some programs aim to reduce substance abuse directly, so prevention-related outcome measures are appropriate. Others strive to affect the risk factors that appear to be associated with substance abuse, such as poor school performance or problem behaviors. For these strategies, evaluators should choose instruments that measure the risk factors that have been targeted. This guide describes instruments that are appropriate for use with youth and their families.

The Purpose of This Document

This document is intended as a starting point for those responsible for evaluating youth substance abuse prevention programs. It provides a brief discussion of issues that are important to consider when evaluation instruments are being selected. More than that, it is a basic reference tool that includes nuts-and-bolts information about the reliability, validity, appropriateness, costs, sources, and the like of 59 instruments relevant to youth substance abuse.

The guide is a shortcut through the vast amount of scientific literature on testing and presents practitioners with options for making informed decisions as they plan their evaluations. It is hoped that this information will provide helpful insights for preventionists involved in the crucial work of program evaluation.

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Introduction

Substance abuse is a common problem in States and communities, and many young people are affected. The initiation of substance abuse and progression to more frequent or heavier use are preventable. Prevention is not easy. Not every strategy that seems appropriate on an intuitive level is effective. Strategies that are effective require specific conditions to have their full effect. Determining the effectiveness of strategies, and the need for adjustments in approaches, requires careful evaluation using measures that have proven effective in capturing the change produced by the strategies.

The purpose of this guide is to demonstrate to practitioners the appropriate methods for selecting instruments for evaluating strategies for youth and their families. This guide briefly presents some of the issues involved in evaluating substance abuse prevention programs and then provides specific examples of evaluation instruments in detail. The guide focuses more on youth than adults; on individual and family-level factors rather than environmental factors such as policies and their enforcement, availability, and prices; and on prevention rather than treatment. The measurement issues and the instruments presented provide some examples that may be useful to practitioners and evaluators. More comprehensive publications are available for those seeking to probe deeply into evaluation issues (see, for example, SAMHSA/CSAP's *A Guide for Evaluating Prevention Effectiveness*, which is in preparation). This guide is a starting place for the selection of appropriate instruments to evaluate substance abuse prevention strategies for youth and their families.

Each instrument discussed in this guide is accompanied by examples of studies in which it was used, information about obtaining copies of the instrument, evidence of its usefulness, and other relevant information. The evidence of the usefulness of an instrument includes the following:

- ◆ An established link between what the instrument measures and some aspect of substance abuse behavior.
- ◆ An appraisal of the degree to which the instrument measures what it was designed to measure (validity).
- ◆ An appraisal of the degree of interrelatedness among the items (internal consistency) and the degree to which the instrument provides consistent results from one evaluator to another (interrater reliability) and from one time to another (retest reliability).

This guide is presented in four parts. Part I discusses the issues involved in evaluation. Part II describes individual and family risk factors for substance abuse. Part III describes outcomes of relevance to prevention efforts. Measures of both risk factors and outcomes presented in Parts II and III are described in detail in Part IV. The guide is intended to act as a basic introduction and a reference tool and to be of practical use to substance abuse prevention practitioners.

Part I:

Issues in Evaluating Substance Abuse Prevention Programs

Introduction

Evaluation is useful in both improving the quality of substance abuse programs and measuring the effectiveness of strategies. Part I describes the process of selecting factors and program outcomes and instruments; judging the quality of instruments and indicators; and determining whether to address individual, family, or environmental level interventions (or a combination). Options for data collection methods are discussed briefly. Finally, the need to select instruments appropriate for the specific target population and some general cautions about evaluation are reviewed.

I. Selecting Factors and Program Outcomes and Instruments

Program evaluators in the substance abuse field often face two key difficulties: (1) deciding on the particular factors and outcomes they wish to measure and (2) locating reliable and valid instruments to measure those factors and outcomes in the diverse groups targeted by prevention efforts. The obvious outcomes desired from prevention strategies include lower levels of substance abuse or related problems or lower rates of initiation of substance use. In short-term programs for younger children, measuring substance abuse as an outcome may be impractical because the effects of the strategies on initiation and abuse may not be seen until several years later. Instead, measuring the hypothesized causes of substance abuse, factors that may be altered through the use of specific strategies, may be a more appropriate approach to assessing the effectiveness of prevention strategies in many cases. In such cases, the preventable risk factors selected for measurement should be those that have the highest possible association with substance abuse levels, and thus the highest potential for demonstrating the impact of the prevention strategies.

Many instruments have been proposed to measure risk factors for substance abuse that are alterable through prevention strategies. A number of directories of instruments relevant to substance abuse prevention are already available to program evaluators. These are listed and described in Appendix A.

Observers have noted the difficulty of locating appropriate instruments, particularly those that are culturally sensitive to the various age, gender, and ethnic groups targeted by prevention efforts (CSR Incorporated, 1992; Madison, 1991; Orlandi, Weston, & Epstein, 1992). Whereas some progress has been made in developing prevention programs that can be focused on different target populations, there has been less progress in determining the extent to which different measures can be meaningfully applied across diverse groups in evaluation studies.

Evaluations can be made more meaningful by following a logical sequence of steps, outlined below, in the selection of outcomes and instruments appropriate for the target population of interest (see also Gottfredson, 1984b).

1. Identify the specific substance abuse problem(s) to be addressed.

2. Identify overall goal(s) to be evaluated. These should be stated in terms that make measurement straightforward; that is, how much change in an outcome of interest is required to conclude that the goal has been met?
3. Identify the program's target population. Who will receive the program's services?
4. Develop the theoretical framework for the evaluation. Use social science theory to develop an explanation for why the target substance abuse problem exists; identify the psychological, behavioral, or social factors that are correlated with the target substance abuse problem or for which they act as precursors of substance abuse. Develop a conceptual model that illustrates how changing beliefs, attitudes, behaviors, or environmental conditions will reduce the target substance abuse problem.
5. Determine which factors can be feasibly addressed. Develop an evaluation model that depicts the relationship between the intervention (i.e., services, program component, program) and the factors (e.g., attitudes, behaviors) the program is designed to change.
6. Specify the program's objectives based on the factors included in the evaluation model, making sure they are stated in measurable terms. A program should have at least one intervention designed to achieve each program objective.
7. Establish implementation standards for the program, including target levels of service delivery (e.g., number of individuals served, coverage of targeted geographic areas or groups at high risk) and timelines for the delivery of services or program components.
8. Regularly monitor progress toward achieving implementation standards. A program that has not been adequately implemented will not produce a measurable change in either intermediate effects or long-term outcomes. In such a case, it may be wise to not pursue the evaluation further.
9. Use information from the monitoring of implementation to redesign programs or methods of service delivery as appears necessary. Once a program has produced measurable effects on factors that contribute to reducing substance abuse, further evaluation can be conducted to assess the program's impact on long-term outcomes.
10. Identify in which category—individual or family—each goal and objective belongs.
11. Locate the factor that corresponds most closely to the goal or objective. Review the literature on that factor to make sure it matches the program's target outcome.
12. Find the appropriate measures for the target outcome and identify which instruments are appropriate for use with the target population. Instruments should have reliability and validity data for that population.
13. Review the information published about each instrument and consider the following issues:
 - ◆ Does the content of the items correspond to the goals or objectives of the intervention?
 - ◆ How many items are in the instrument?
 - ◆ What reading level is required to comprehend the items?
 - ◆ How long will it take to complete the instrument?
 - ◆ Will any special administration procedures be required that are not feasible?
 - ◆ How difficult is it to score the instrument?
 - ◆ Have the instrument's reliability and validity been assessed with populations similar to the target population?

- ◆ Is there any evidence that the instrument works well for the target population? For example, are its content and administration culturally appropriate and matched to the respondents' abilities and skills?
 - ◆ What are the costs associated with using the instrument, including costs to purchase, administer, and score it?
 - ◆ Can the instrument be easily obtained?
14. If doubt exists about the usefulness of an instrument for the intended target population, conduct a pilot test on a small group selected from the target population. Examine the results for evidence of appropriateness.
 15. Define the population that will be sampled. Determine whether a control or comparison group will be used and define that sample.
 16. Develop administrative procedures and a schedule for administering the instrument to the target population and the control or comparison group (if one has been selected). Administrative procedures should include methods to ensure confidentiality.
 17. Arrange to obtain informed consent from the subjects. Parental consent may be necessary if the study population includes minors.

II. Judging the Quality of Instruments

The two main criteria for judging the quality of instruments used in prevention evaluations are reliability and validity. *Reliability* refers to the degree to which scores derived using an instrument are free from error. A reliable measure is one that varies because the level of the factor being measured varies, not because of extraneous factors or error. Conducting an evaluation with an unreliable instrument is like building a house using an elastic tape measure.

There are many ways to assess the reliability of measurement because there are many different sources of error. If people are assessed in the same way on two occasions, they will often be rank ordered in more or less the same way on both assessments. If not, the assessment is said to have low *retest reliability*. Retest reliability is an example of one kind of reliability information—a kind that is especially pertinent if stability of measurement over time is an issue.

Often evaluators are called upon to measure factors that are expected to change over time. In these instances, the evaluator should be more concerned that scores are relatively free of error each time they are measured than that scores exhibit very high retest reliability. Estimates of single-occasion *internal consistency* among items in the instrument are sometimes useful because they do not include differences over time in the definition of error.

Validity reflects the degree to which inferences made based on the instrument are supported by evidence and theory. Evidence about the validity of inferences is the most important technical criterion by which the quality of measurement instruments should be gauged. Inferences are most likely to be valid when they are based on instruments that have produced evidence that they in fact measure the particular factor (e.g., behavior, attitude, belief) they are intended to measure. Conducting an evaluation with an instrument that is not valid is similar to measuring blood pressure with a thermometer. The thermometer is measuring something, but that something is not what was intended. There are many ways to judge the extent to which an instrument will provide a basis for a valid inference. Some of these are discussed in the glossary (Appendix B).

III. Considering the Level of Intervention in Selecting Instruments

Prevention programs may aim their services at three levels of intervention: individuals, groups (e.g., families, schools), and environments. As mentioned earlier, this guide examines instruments useful only at the individual and family levels. A key concern is that the level of measurement of evaluation instruments matches the level of program intervention. For example, if individuals are assigned to receive skills training as part of a prevention program, the evaluation instruments should be geared toward measuring change at the individual level. When a program targets a group for change, such as a family or peer group, measures selected for evaluation should have demonstrated reliability and validity at that level.

Pertinent evidence of reliability and validity for measures of social groupings comes from studies conducted at the group level. For example, instruments purporting to measure factors in family environments should be based on average responses of different family members rather than the perceptions of one family member. Developers of such instruments might provide evidence of stability of this family average over time (retest reliability) or of the consistency of the reports of different members of the family (interrater reliability or intraclass correlation).

IV. Options in Data Collection

Data for the evaluation of prevention programs can come from a variety of sources, including surveys (written self-report survey and interview), archives, observations, and biological specimens. Each source is described briefly below. The selection of instruments in program evaluation partly depends on the resources available for carrying out different approaches to data collection. More extensive discussions of the benefits and limitations associated with each data source can be found in research methods handbooks (e.g., Judd, Smith, & Kidder, 1991; Kerlinger, 1986) and in some of the directories listed in Appendix A.

Surveys can involve paper-and-pencil questionnaires, telephone or face-to-face interviews, or checklists completed by people with knowledge about an outcome of interest. Surveys often provide an efficient method for prevention program evaluation. They are direct, relatively inexpensive, and can be tailored to specific evaluation needs. Often they provide the only practical method of obtaining information. For example, it is difficult to see how attitudes about substance abuse could be measured without asking respondents to report about their attitudes in an interview or a pencil-and-paper questionnaire.

Much debate and research has surrounded the issue of validity of self-reports, particularly of substance abuse. Many find it hard to believe that people will tell the truth when asked by a stranger to report on their illegal behaviors. However, research has generally supported the validity of self-reports in research on substance abuse and other illegal behaviors, although survey results should always be interpreted with caution and in light of the tendency for individuals to report less substance abuse than actually goes on (Forman & Linney, 1991; Harrison & Hughes, 1997; Hindelang, Hirschi, & Weiss, 1981; Lauer, Akers, Massey, & Clarke, 1982; Murray & Perry, 1987; National Institute on Drug Abuse [NIDA], 1985, 1997). Some level of error in measurement is expected and even acceptable in research as long as the error is random or distributed evenly across subjects. Less research is available on the issue of cultural differences in the validity of self-reports, but one recent study (Wallace & Bachman, 1993) documented that large racial and ethnic differences in self-reported drug use are generally valid and reliable. Wills and Cleary (1997) found the same for different smoking rates for Whites and African Americans.

Archival records are normally kept as part of the operation of an institution or organization and are usually collected for a purpose other than research. These records include school records of academic success and behavior problems and police and juvenile service records of contacts with law enforcement agencies. Often in evaluation research, there is some question about the extent to which the process of surveying or observing individuals may alter their behavior in ways that are not known to the researcher. The use of archival records can provide information unobtrusively and hence can reduce the threat of bias resulting from the individuals' knowledge of being monitored by researchers. Drawbacks to using archival records in research include difficulties in gaining access, incompleteness, and the possibility that they contain systematic errors. Because they are not collected specifically for research purposes, they may often fail to capture the factors of interest to those conducting program evaluations.

Observations, on the other hand, are likely to yield more valid information. Although a survey itself may act as a change agent for those being assessed, and the wording of the questions in a survey may influence responses, unobtrusive observation can produce direct measurement of the behaviors of interest. Observations generally try to capture the individual in a natural setting and systematically count the behaviors, and they are generally a more expensive undertaking than surveys or collecting archival data. To the extent that the subjects of research are aware of being observed, they may respond in atypical ways, for example, by behaving in ways they believe will please the observer. Often, however, observations can be accomplished without the knowledge of the individuals being observed, such as in a classroom by a teacher, aide, or another trained observer.

Another data source that is of special interest in the evaluation of substance abuse prevention projects is the analysis of physical samples (e.g., blood, urine, hair). This source about substance involvement entails greater expense and various constraints on validity (NIDA, 1997). A limitation on the source's utility for use in social programs is its obtrusive nature. Clearly, asking participants in prevention programs for urine samples may produce feelings of discomfort or distrust—feelings likely to produce a negative program climate.

Each of these data sources can provide useful measures of prevention outcomes. The selection of a data source will depend on the characteristics of the study population and the type of information required. A self-report written survey instrument, for example, will not be suitable for a very young or illiterate population. The use of multiple data sources is ideal in evaluation because the biases inherent in one source can be balanced by another source. Most of the measures summarized in Part IV of this volume are self-report instruments or rating forms that must be completed by study participants or other individuals who can report about the study participants. The tendency for program evaluators to favor survey measures is due to practical considerations of availability, cost, and ease of use.

V. Determining Instrument Appropriateness for Different Target Populations

A challenge facing the prevention field is that of locating high-quality measures of prevention outcomes that are recognized as important for the diverse populations served by prevention programs. There are reasons to expect that the quality of measurement provided by a given instrument might vary by group. Just as the measurement instruments must change to meet the developmental needs of maturing populations, so might they have to differ for people from different cultural backgrounds. Characteristics of populations related to measurement reliability include reading ability,

attention span, motivation, vision, hearing, and language capacities. Characteristics of the instruments may interact with characteristics of the populations being assessed to produce variable reliability. Test length, response formats, choice of language, and reading level of an instrument are all variables that can be manipulated to increase assessment reliability and validity for different groups.

When doubt exists about the usefulness of an instrument for a particular population, pilot testing within the target population is recommended. If low reliability is found for a population, a different instrument should be sought. It is also possible that the same instrument could measure different underlying factors for members of different groups. Thus an instrument could be equally reliable for different groups but differentially valid. Beauvais and Trimble (1992) have provided a perspective on measurement differences and similarities across groups that is relevant to these concerns.

Acceptability among the subjects of a program evaluation is as important as the technical adequacy of instruments. Instruments may be reliable and valid, but if they are regarded as degrading, irrelevant, or otherwise inappropriate for members of a group, they are likely to prove difficult to use in program evaluations. Using inappropriate instruments with populations that may be distressed or otherwise harmed by their use raises ethical concerns. If such a possibility exists, steps to uncover and correct the source of potential harm should be undertaken. More difficult problems occur when a group objects to any form of systematic assessment or evaluation. Some problems of cultural conflict or mistrust are problems of political and intergroup relations—not problems of measurement.

It is often assumed that available instruments have different reliability and validity across different cultural groups, but there is little dependable evidence against which to test this assumption. In the search for instruments that measure prevention outcomes, relatively little information about the equivalence of measurement for the diverse populations typically involved in evaluations of prevention efforts is available. A few instruments, however, are supported by published test manuals and primary studies that provide evidence of reliability and validity separately for members of different ethnic and gender groups.

VI. Some Cautions for Evaluators of Prevention Programs

Evaluators should exercise caution when generalizing from research findings. Two cautions are discussed in this section that will alert evaluators to possible misinterpretations of research that could lead to program design flaws or inappropriate instrument selection that will result in failure to measure prevention program effects accurately.

First, a common mistake made by both experienced evaluators and those less familiar with evaluation methodology is to equate correlation with causality. Randomized experiments conducted in controlled settings that use procedures to prevent extraneous forces from having influence are generally required to establish causality. Few studies have been conducted that establish a causal link between risk factors and substance abuse. Many studies, however, have established a *correlation* between substance abuse and those attitudes, behaviors, and conditions commonly referred to as risk factors.

A related advisory is that program evaluators should guard against selecting instruments to measure outcomes before crucial questions about the target population and expected effects of the intervention have been answered. Because it is not always feasible to track program participants

for several years to determine whether the program affects substance abuse, factors that are thought to be precursors of subsequent substance problems may be selected as outcome variables. In such a case, an early step in the design of an evaluation should be a critical review of research literature to determine the extent to which attitudes, behaviors, or other factors targeted for intervention are associated with substance abuse outcomes.

Other important issues in the selection of appropriate outcomes include considering whether characteristics of the target population could affect program impact, whether interventions are appropriately matched to the stage of substance abuse in the target population, and whether the intervention is powerful enough to achieve the desired impact. First, although research may show a correlation between a particular factor and later substance abuse in one particular group, it should not be assumed that the same association exists for all age, gender, and cultural groups. A particular variable should not be used as a program outcome unless empirical evidence exists to show a correlation between the variable of interest and substance abuse for a population comparable to the one being served by the program at hand.

Second, an issue that should be examined prior to selecting program outcomes is whether the targeted attitudes or behaviors are associated with *first use* or *experimentation*, with *regular use*, or with *addiction*. Just as the type of intervention must be matched to the program's target population, the scope and intensity of the intervention should be matched to the severity of substance problems in the target population. For instance, if a program's goal is to prevent adolescents from experimenting with substances, there should be empirical evidence that the selected program outcome variable is in fact correlated with experimentation or early initiation, rather than with regular substance abuse or addiction.

Part II: Risk Factors for Substance Abuse

Introduction

Many individual and family factors have been found to be correlated with substance abuse. Some of these factors may play a causal role, while others have a coincidental association or are spurious. Prevention strategies are designed to affect some possibly causal factors (risk factors), but other factors are part of the background of the individual or are not possible to change. For example, a family history of substance abuse is one of the factors associated with substance problems in children, and gender is associated with greater or lesser risk of substance problems, with boys being more likely to develop some problems. Prevention strategies may be aimed at children who are at higher risk because of these factors, but the strategies do not attempt to change the factors themselves.

When a prevention strategy is designed to change a risk factor, an evaluation of that strategy should measure any changes in the factor. Changes in the factor in the desired direction can be considered a positive outcome of the program. This guide provides a discussion of factors that have been found most consistently associated with substance abuse, whose association with substance abuse is most likely to be causal, and that are likely to be considered outcomes of prevention strategies. For each of the risk factors presented in Part II, available measurement instruments are described in Part IV. Table 1 lists the factors covered in this guide. Two types of risk factors are discussed: individual level and family level. In each of these categories several factors are described.

Table 1. Factors Associated With Substance Abuse and Other Outcomes

Individual-Level Factors	Family-Level Factors	Outcomes
<i>School-related attitudes and behaviors</i> Attachment to school Commitment to education School performance	<i>Family structure, attitudes, and processes</i> <i>Substance use in the family</i> <i>Parental attitudes favorable to substance use</i>	
<i>Peer influence</i> <i>Conduct problems</i> <i>Impulsivity/low self-control</i> <i>Belief in conventional social rules</i> <i>Attitudes favoring substance abuse</i> <i>Social competency skills and peer rejection</i>	<i>Family processes</i> Conflict Monitoring and supervision Discipline practices Support and attachment	<i>Substance Abuse</i> <i>Other Related Problem Behaviors:</i> Crime and delinquency High-risk sexual activity Dropout and truancy

I. Individual-Level Risk Factors for Substance Abuse

Most of the factors addressed in prevention programs are at the individual level. This section discusses some of the more commonly considered factors.

A. School-Related Attitudes and Behaviors

Attachment to School and Commitment to Education. Consistent evidence from more than 25 years of research shows that attachment and commitment to school are inversely related to delinquency and substance abuse for children in elementary through high school (see, e.g., Gottfredson, 1984a; Hirschi, 1969). Attachment and commitment to institutions such as school are central constructs in Hirschi's social control theory of delinquency. According to social control theory, individuals who are highly bonded to conventional institutions are less likely to engage in delinquent activities than those with weak bonds. *Attachment* to school refers to the extent to which an individual likes school. For example, a youth who likes school and experiences school in a positive way is less likely to engage in behaviors that violate school rules. *Commitment* refers to psychological investment in the pursuit of a goal. A person with high educational aspirations is more committed to school than one who has no such aspiration. Commitment is a motivational aspect of an individual's bond to society. An individual's commitment restrains him or her from violating social norms and participating in delinquent behaviors. For example, a youth who is invested in education is less likely to engage in behaviors that may jeopardize the chance of attending college.

Three measures of attachment to school or commitment to education are presented in Part IV. Measure 1 is the National Youth Survey (NYS), with its subscales on Academic Aspirations and School Involvement. Measure 2, What About You (WAY), has subscales on Attachment to School and Commitment to Education.

School Performance. School performance is operationally defined by school grades, whether from self-report or from school records, and grade retentions. Consistent evidence has established the relationship between poor school performance and substance abuse and other adolescent problem behaviors. School grades have been shown to be moderately related to substance abuse (Graham, 1996; Kingery, Pruitt, Brizzolara, & Heuberger, 1996) for youth from middle school to college. Measure 3, Self-Reported Grades, in Part IV, presents no specific instrument.

B. Peer Influence

Most research examining peer association and involvement in substance abuse has examined high school samples. A few studies show that exposure to negative peer influences among younger children is associated with early substance abuse or other problem behaviors (see, e.g., Gottfredson & Gottfredson, 1992b). Several studies using longitudinal data have demonstrated a strong relationship between peer associations and substance abuse (e.g., Brook, Brook, Gordon, Whiteman, & Cohen, 1990; Castro, Maddahian, Newcomb, & Bentler, 1987; Elliot, Huizinga, & Ageton, 1985; Farrell & Danish, 1993; Jessor & Jessor, 1977; Pruitt, Kingery, Mirzaee, Heuberger, & Hurley, 1991).

Association with peers who abuse substances and engage in other delinquent behaviors is one of the strongest correlates of adolescent substance abuse and delinquency. Studies repeatedly demonstrate a strong association between peer problem behavior and a person's own substance abuse and problem behavior. Many longitudinal and cross-sectional studies in addition to those cited here confirm this relation. Negative peer influence has been measured in a variety of ways—such as the

raw number or proportion of friends who use alcohol, tobacco, or other substances; the amount of time spent with these friends; whether or not friends have offered the respondent various substances; and whether or not friends feel pressured to use substances. For populations in which children are so young that few engage in substance abuse, a measure of the number or percentage of friends who engage in rebellious or aggressive behavior might be used as a measure of negative peer association.

Four measures presenting five scales that assess peer influence are presented in Part IV. Measure 4 is the American Drug and Alcohol Survey's (ADAS) Peer Drug Associations subscale. Measure 5 includes scales on Positive Peer Influence and Peer Drug Models. Measure 6 is the Survey of Youth's Differential Peer Associations scale. Measure 7 is the Interaction with Antisocial Peers and Friends' Use of Drugs subscales of the Communities That Care Youth Survey.

C. Conduct Problems

In this section, the emphasis is on early problem behaviors, or conduct problems, as a predictor of later substance abuse and related problem behaviors. Conduct problems subsume a variety of superficially diverse behaviors: defiance, disrespect, rebelliousness, hitting, stealing, lying, fighting, talking back to persons in authority, and the like. These behaviors are usually chronic, and individuals differ in the levels they display—maintaining their rank order in a relatively stable manner over time. This stability makes the early displays of conduct problems useful predictors of several types of later problem behaviors. Longitudinal studies support this phenomenon (e.g., Bachman, 1975; Block, Block, & Keyes, 1988; Elliot, Huizinga, & Ageton, 1985; Kellam, Ensminger, & Simon, 1980; Shedler & Block, 1990). Because problem behavior is more likely to be noticed in children if it is extreme, those whose problem behavior is noticed earliest more often display more problem behavior later on. This finding accounts for the frequent observation that early onset of substance abuse or other problem behaviors predicts continued problem behavior (Robins, 1978; Robins & Pryzbeck, 1985).

Six measures of conduct problems are included in Part IV. Measure 8 is the Externalizing subscale of the Child Behavior Checklist (CBCL) and Teacher's Report Form (TRF). Measure 9 is the Conduct Problem subscale of the Conners' Rating Scales (Teacher and Parent Rating Scales). Measure 10 is the subscale for Rebellious Behavior in School from the Youth in Transition (YIT) Survey. Measure 11 is the Antisocial Behavior subscale of the Rutter Child Scale (Teacher Report). Measure 12 is the Conduct Disorder subscale of the Revised Behavior Problem Checklist (RBPC)-PAR Edition. Measure 13 is the Early Initiation of Problem Behavior subscale of the Communities That Care Youth Survey.

D. Impulsivity or Low Self-Control

Impulsivity is a disposition to behave without thinking first in a wide range of situations and doing so more or less consistently over time. Unlike many other traits, impulsivity shows a tendency to decrease in the individual with increasing age. The issue of impulsivity (also referred to as low self-control), apart from other problem behaviors and substance abuse, has not been studied much. What evidence there is implies a moderate connection between this personality dimension and substance abuse or other delinquent behavior, especially when it is measured as acting without thinking rather than as sensation-seeking behavior (see, e.g., Block et al., 1988; Heaven, 1993; Labouvie & McGee, 1986).

Five measures of impulsivity and self-control are included in Part IV. Measure 14 is the Impulsivity scale from Impulsiveness-7. Measure 15 is the junior version of this Impulsivity scale. Measure 16 is the Dysfunctional Impulsivity subscale of the Functional and Dysfunctional Impulsivity Scale. Measure 17 is the Self-Control Rating Scale (SCRS) (Teacher Rating). Measure 18 is the shortened form of the Teacher's SCRS, with subscales for cognitive, personal behavioral, and interpersonal components.

E. Belief in Conventional Social Rules

Belief in conventional rules means an endorsement or internalization of widely shared social rules, norms, proscriptions, prescriptions, or laws. Persons high in conventionality are conscientious, conforming, and respectful of authority; they are concerned about meeting their obligations to others, and they follow rules. Belief scales usually measure a respondent's attitudes toward norms, rules, and laws. Many scales list deviant behaviors and ask respondents to indicate how wrong they feel each act is; other scales ask respondents to endorse or reject statements reflecting sentiments about social rules. Existing research suggests that belief in conventional rules is associated with lower probabilities of substance abuse (see, e.g., Gottfredson & Gottfredson, 1992a; Jessor, Donovan, & Widmar, 1980; Smart & Fejer, 1971).

Part IV includes three measures of beliefs in conventional social rules. Measure 19 is the Belief in Rules subscale of the What About You survey, with two forms. Measure 20 is the Research Triangle Institute (RTI) Panel Study Survey, which examines attitudinal tolerance of deviance. Measure 21 is the Attitudes Favorable Toward Antisocial Behavior and Belief subscales of the Communities That Care Youth Survey.

F. Attitudes Favoring Substance Abuse

Attitudes favoring substance abuse are specific beliefs that dispose individuals to respond to opportunities to abuse substances in certain ways. These attitudes involve four somewhat distinct facets: (1) expressed intentions about use; (2) expressed beliefs that substance abuse is acceptable; (3) perceptions of users or use of a substance as socially attractive; and (4) perceptions that using substances is not harmful. Research shows a relationship between favorable attitudes toward substance abuse and actual use (see, e.g., Kingery, Pruitt, & Hurley, 1992; Pruitt et al., 1991; Wang, Fitzhugh, Eddy, & Westerfield, 1996).

Three measures of attitudes favoring substance abuse are included in Part IV. Measure 22 is the Drug Attitudes Scale. Measure 23 is the Definitions Favorable/Unfavorable to Use subscale of the Survey of Youth. Measure 24 is What About You, and includes two scales: Attitudes Favoring Drug Use and Intentions to Abstain.

G. Social Competency Skills and Peer Rejection

Persons high on social competency successfully control anger, aggression, and hostility, and recognize and control their emotions so that they can make socially competent responses in problem situations. As a result they are less likely to be rejected by their peers. Social competence describes the quality of a person's response in a problem situation. Socially competent behaviors are thought to be the result of a sequence of beliefs and behaviors that result in resolving an immediate problem while minimizing the likelihood of future problems. These beliefs and behaviors are often collectively referred to as coping, problem-solving, or decisionmaking skills.

Research has linked judgments of social competence (by self, peers, and adults) with later problem behaviors including substance abuse (see, e.g., Block et al., 1988; Dishion, 1988; Ollendick, Oswald, & Francis, 1989; Shedler & Block, 1990; Smith & Fogg, 1978). These studies and many others illustrate that certain individuals possess a constellation of characteristics, including defiance, poor impulse control, and aggression, that places them at risk for several problem behaviors. People with these characteristics are less likely to resolve immediate problems, while minimizing the likelihood of future problems, and they are inclined to have more future problems.

Social competency—as measured by self, peers, teachers, and other adults—is related to later problem behavior, including substance abuse. The relationship has been established for youths from 3 years old to adolescence. The research has been conducted primarily with European-American samples, but at least one strong study replicates the finding with African Americans. The association may be completely or partly due to the overlap of social competency behaviors assessed and personal characteristics, such as defiance, impulsivity, dishonesty, and aggression, which are known to predict problem behavior.

Part IV includes four measures with social competency scales. Measure 25 is the peer-rated Peer Rejection scale. Measure 26 is the Social Skills Rating System (SSRS), which includes ratings from teachers, parents, and students. Measure 27 is the elementary version of the Walker-McConnell Scale of Social Competence and School Adjustment (rated by teachers), which measures teacher- and peer-preferred social behaviors. Measure 28 is the adolescent version of the Walker-McConnell Scale, which measures self-control, peer relations, and empathy.

II. Family-Level Risk Factors for Substance Abuse

Aside from individual-level factors, characteristics of various social groups to which individuals belong, most notably characteristics of families, may be related to substance abuse and other long-range outcomes. Following is a discussion of three aspects of families that are related to substance abuse in children of those families: substance abuse in the family, parental attitudes toward substance abuse, and family processes.

A. Substance Use in the Family

Substance use in the family has been defined as a parent's or sibling's use of alcohol, tobacco, or other substances and is measured by the frequency of use or the quantity of use. Research consistently finds a positive relationship between family and adolescent substance abuse, although the strength of the association differs from study to study. Studies based on adolescent reports of parental substance abuse and their own substance abuse have found large associations between adolescent and parental use (Johnson, Shontz, & Locke, 1984; McDermott, 1984). In some studies, researchers separately ask adolescents and their parents about the quantity and frequency of alcohol, tobacco, and/or other substance consumption and find weak to moderate associations between parent use and adolescent use (see, e.g., Barnes & Welte, 1986; Needle et al., 1986; Williams & Covington, 1997).

Other studies have collected information on parental substance abuse at one time and high school students' substance abuse at a later time (see, e.g., Brook et al., 1990; Kandel, Kessler, & Margulies, 1978) and found weak to moderate positive associations. Research examining the relationship between sibling and adolescent substance abuse generally shows stronger linkages (see, e.g., Cata-

lano et al., 1992; Needle et al., 1986). In sum, a weak to moderate positive relationship has been found between parent and child substance abuse among youth aged 11 to 18.

Two measures of substance abuse in the family are included in Part IV. The first is a series of items measuring family history of substance abuse (Measure 29). Measure 30 is the Family History of Antisocial Behavior subscale of the Communities That Care Youth Survey.

B. Parental Attitudes Favorable to Substance Abuse

Parental attitudes favorable to substance abuse are defined as parental permissiveness toward, or tolerance of, their children's substance abuse or of adolescent substance abuse in general. Research indicates that parents' attitudes toward substance abuse are more weakly linked with adolescent substance abuse than are youths' reports, or perceptions of their parents' attitudes (Brook, Gordon, Whiteman, & Cohen, 1986; Kandel et al., 1978). *Adolescent* reports of parental attitudes and adolescents' use are usually moderately associated (see, e.g., Barnes & Welte, 1986; Catalano et al., 1992; McDermott, 1984). Thus, the literature shows a weak to moderate association between parental attitudes favorable to substance abuse and adolescent substance abuse. Smaller effects have been found for actual parental reports. This association has been established for youth aged 11 to 20 of various ethnic backgrounds. Measure 31 in Part IV is a series of items measuring parental attitudes toward substance abuse.

C. Family Processes

Four aspects of family processes have been found to be associated with substance abuse. These include family conflict, monitoring and supervision, discipline, and family support and attachment.

Family Conflict. Family conflict consists of adult partner- or parent-child conflict (fighting, verbal or physical abuse going in either or both directions), and parental aggression toward, or abuse of, children. Spousal or living-partner conflict, parent-child conflict, and parental aggression toward, or abuse of, children have all been shown to be positively related to substance abuse or other problem behaviors in children, adolescents, and adults (see, e.g., Brook et al., 1990; Cernkovich & Giordano, 1987; Dembo, Dertke, Borders, Washburn, & Schmeidler, 1988; Dembo, Williams, et al., 1988; McCord, 1979; Simcha-Fagan, Gersten, & Langner, 1986; Vissing, Straus, Gelles, & Harrop, 1991). Positive associations have usually been found between youth behavior problems, including substance abuse, for children as young as 24 months, as well as adolescents.

Four measures of family conflict are included in Part IV. Measure 32 is the Conflict subscale of the Family Environment Scale (FES) C (family member reports). Measure 33 is the Verbal Aggression and Violence subscales of the Conflict Tactic Scale (CTS) (adolescent and parent reports). Measure 34 is the O'Leary Porter Scale (OPS) (parent reports). Measure 35 is the Conflict Behavior Questionnaire (CBQ) (adolescent and parent versions).

Monitoring and Supervision. Monitoring or supervision refers to parents' awareness of their child's peer associates, free-time activities, and whereabouts when outside the home. Effective monitoring may also require clear communication of a set of rules about when the child should be home from school, weekday and weekend curfews, persons with whom the child may not associate, places that are off-limits to the child, and activities (including substance abuse) forbidden by the parents. Both self-reports and observations confirm that monitoring and supervision are

inversely related to substance abuse and other problem behaviors (see, e.g., Block et al., 1988; Cernkovich & Giordano, 1987; Dishion, Patterson, Stoolmiller, & Shinna, 1991; Gottfredson & Gottfredson, 1992a; Hirschi, 1969; McCord, 1979).

In short, lack of parental monitoring or supervision has been demonstrated to be related to problem behavior, using a variety of methods (self-report, observation, official records). Monitoring or supervision has consistently been shown to have a moderate to strong negative association to substance abuse and other problem behaviors.

Three measures of family monitoring and supervision are included in Part IV. Measure 36 is the Parental Supervision scale of the WAY Survey (forms C and E). Measure 37 is the Control and Supervision subscale of the Family Instrument. Measure 38 is the Mother and Child Reports of parental monitoring, mother-child difference score, reports of supervision hours, and Mother Report of Discipline, all from the Oregon Youth Study (form C, mother and child reports).

Discipline. Discipline refers to methods used by family members to discourage inappropriate or antisocial behavior in children. Effective methods of discipline generally consist of (1) the accurate definition and labeling of antisocial behaviors as unwanted; (2) the consistent tracking of those behaviors over time and across settings; and (3) the consistent use of effective, but not harsh, methods to inhibit those behaviors. Inconsistent discipline is illustrated when parents punish their child for doing something one day but do nothing about the same behavior at another time, perhaps depending on the parent's mood. Harsh discipline is discipline that is consistently punitive or involves verbal or physical abuse or threats of physical punishment, such as punching or slapping. Lax discipline is defined as discipline in which parents give in, allow rules to go unenforced, or provide positive reinforcement to misbehavior.

Research implies that inconsistent, harsh, and lax discipline are related to substance abuse and other problem behaviors in children (see, e.g., Arnold, O'Leary, Wolff, & Acker, 1993; Gove & Crutchfield, 1982; Lempers, Clark-Lempers, & Simons, 1989; McCord, 1979; Vicary & Lerner, 1986; Williams, Clinton, Winfree, & Clark, 1992). Measure 39 in Part IV is the Lax Discipline and Overreactivity subscales of the Parenting Scale (form C, parent reports).

Family Support and Attachment. Parental support is behavior toward a child that makes the child feel comfortable and confirms in the child's mind that he or she is accepted, approved of, and loved. Support can also be thought of as an accumulation of parental praise, approval, encouragement, help, cooperation, and expression of affection. Support has variously been labeled acceptance, affection, love, nurturance, or warmth; and its obverse has been labeled hostility, neglect, or rejection. Parent-child attachment is an intense and long-lasting affectional bond between parent and child. Four separate continuous dimensions of parent-child attachment are (1) identification, (2) lack of conflict, (3) warmth, and (4) involvement—the degree of commitment to the parental role and the extent to which the parent centers attention on the child.

Empirical studies and literature reviews consistently find that greater parental support (e.g., warmth, love) is correlated with reductions in problem behavior, including substance abuse, among children. Parent reports, child reports, and observer assessments of parental behavior toward the child show that attachment has been found to be inversely related to problem behavior (see, e.g., Brook et al., 1990; Cernkovich & Giordano, 1987; Kandel & Andrews, 1987; McCord, 1979; McKay, Murphy, Rivinus, & Maisto, 1991; Simcha-Fagan et al., 1986; Vicary & Lerner, 1986). A consistent (but generally weak) relationship has been found between parental support or attachment and adolescent substance abuse in the research. This relationship has been established

for youths aged 3 to 18 and for adults, using a variety of methods (parent and youth report, observations).

Six measures of family support and attachment are included in Part IV. Measure 40 is the Affective Responsiveness subscale of the McMaster Family Assessment Device (FAD) (family member reports). Measure 41 is the Acceptance subscale of the Children's Report on Parent Behavior (CRPBI). Measure 42 is the Cohesion subscale of the Family Environment Scale (FES). Measure 43 is the Caring and Trust and Identity Support subscales of the Family Instrument. Measure 44 is the Cohesion subscale of the Family Adaptability and Cohesion Evaluation Scales II (FACES II). Measure 45 is the Family Attachment subscale of the Communities That Care Youth Survey.

Part III:

Prevention-Related Outcomes

Introduction

The preceding sections have described factors associated with substance abuse and other behaviors. Changes in those factors may, therefore, be considered desirable outcomes of prevention strategies. For example, a reduction in family conflict might be the goal of a program as part of an effort to reduce substance abuse among children.

This section describes a number of negative behavioral outcomes associated with substance abuse, which may be assessed as long-term outcomes of prevention programs (table 1). Certainly reduction in substance abuse is the key objective, but often programs seek to effect changes in other related problem behaviors. These other facets of problem behavior include interpersonal aggression, property crime, sexual activity, and dropping out of school and truancy. Persons who engage in one form of problem behavior are highly likely to engage in others. Biglan et al. (1990) found high correlations between a measure of “high-risk” sexual behavior and measures of antisocial behavior, smoking, alcohol use, and illicit substance abuse.

The links among many facets of problem behavior imply that prevention and treatment programs should anticipate connections between substance abuse, interpersonal aggression, property crime, sexual behavior, and dropping out of school and truancy. All of these are reasonable targets of substance abuse prevention programming, although one should not rule out specific causes of specific problem behaviors. Each of four kinds of outcomes is discussed below.

I. Substance Abuse

Use of tobacco products by anyone under the age of 18 or of alcoholic beverages by anyone under the age of 21 and use of any illicit substance by persons of any age are considered substance abuse. Dimensions of abuse that can be measured distinctly include age of first use (age at onset); status as having used a substance at least once; and current abuse, including frequency of abuse and amount typically abused.

Many measures of self-reported substance abuse are available. Three aspects of abuse are generally measured: (1) whether the individual has ever abused one substance or any of a variety of substances, (2) whether an individual has abused a substance or a variety of substances in a *specified recall period* (last month, last year), and (3) how frequently and how much is used. The first type of questions might ask, “Have you ever used marijuana?” The second type asks, for example, “Have you used marijuana in the last year?” And the third type might ask, “How many times in the last month (or year) have you used marijuana?” or “How many cigarettes do you smoke a day?”

The type of question (ever used, used in recall period, or frequency or quantity) and the length of the recall period (day, week, month, year) should be tailored to the evaluation question and the population being studied. Because substance abuse is less common for elementary school children, “ever used” questions (sometimes called lifetime prevalence questions or initiation questions) or “used in the last year” questions may be most appropriate. Few elementary school children would

report much frequent abuse, and relatively small proportions of children would report use in very short recall periods. For adolescents in high school, questions about the frequency of abuse in the past month may be of great importance, especially for substances that are abused by a large percentage of youths.

The specific substances to include in substance abuse questions should also be tailored to the research question and the age and risk status of the study population. Some instruments are available in different versions for different age groups.

The length of recall periods should be tailored to match the period of intervention. It would not be wise to attempt to assess the efficacy of a 3-week intervention to reduce alcohol consumption among high school seniors by using “ever drunk (alcoholic beverage)” questions. Because a very high percentage of high school seniors would have consumed alcohol at some point in their lives, such a lifetime recall question would not be as sensitive as questions with a past-week or past-2-weeks recall period.

Four measures of substance abuse are presented in Part IV. Measure 46 is the alcohol, marijuana, and illicit drug use items from the NYS. Measure 47 is the drug use items from the Monitoring the Future survey. Measure 48 is the substance use items from the ADAS. Measure 49 is the substance abuse scales (forms C and E) of the WAY survey.

II. Delinquent or Criminal Behavior

Delinquent or criminal behavior is any behavior that is against the law. Delinquency is criminal behavior committed by a young person. Laws, and therefore the precise definition of behaviors in violation of the law, vary slightly from State to State. Crime and delinquency include the full range of acts for which individuals could be arrested. They include crimes against persons ranging in seriousness from murder to robbery to minor assault. They include an array of crimes against property ranging from arson to felony theft to joy-riding. Crime and delinquency also include possession, use, and selling of substances. For juveniles, delinquency includes status offenses, such as running away or truancy. A status offense is an offense that is a crime only for a juvenile. Dimensions of crime that can be measured independently include age of first involvement, status as a delinquent ever in one’s life, current criminal activity, and frequency of delinquent involvement.

Three measures of delinquency are included in Part IV. Measure 50 is the General and Offense-Specific Delinquent and Criminal Behavior subscales of the NYS. Measure 51 is the Total Delinquency subscale of the Monitoring the Future (MTF) Survey. Measure 52 is the Antisocial Behavior subscale of the Communities That Care Youth Survey.

III. Sexual Activity

Sexual activity among minors, particularly younger ones, is usually a cause for concern. Risky sexual behaviors are an even greater cause for concern and may include multiple sexual partners; sex with persons not well known to the individual, known to inject substances, or known to be sexually engaged with others; unprotected sex; and anal sex. Having had sexual intercourse at all is also correlated with other problem behaviors for adolescents.

Three measures of high-risk sexual behavior are included in Part IV. Measure 53 is the Scale of AIDS Risk (SAR). Measure 54 is the Sexual Events subscale of the Life Events Questionnaire (LEQ). Measure 55 is the Seven-Point Assessment of Sexual Risk from the Sexual Risk scale.

IV. Withdrawal From School

Leaving school prior to graduation from the 12th grade and truancy are defined as withdrawal from school. The precise definition of truancy differs according to location but generally refers to excessive absence from school. Two measures of withdrawal from school are presented in Part IV. Measure 56 is School Records of Truancy and Dropout. Measure 57 is Self-Report Items Measuring Dropout and Truancy From School from various authors.

Part IV:

Measures of Risk Factors and Outcomes

Introduction

Part IV contains the detailed descriptions of the instruments introduced in Parts II and III. For most measures of factors at the individual and group levels, instruments appropriate for the following different age groups were sought: prekindergarten (age 4 and under); early elementary (ages 5–8); late elementary (ages 9 and 10); early adolescence (ages 11–13); late adolescence (ages 14–17); and adult (ages 18 and older). Whenever practical, the same instrument used in the research that demonstrated a link between the factor and substance abuse is described. When the instrument used in the original research was unavailable or too cumbersome for use in prevention program evaluations, an alternative with content matching the definition of the factor derived from the research was substituted.

The number of available instruments differs from factor to factor. For some factors, only one or two instruments were available for each age group. For others, several were available. Different criteria for inclusion in the final set had to be applied for different sets of measures, depending on the availability of instruments and research in each area. Empirical evidence documenting the psychometric properties (e.g., reliability, validity) of the measures (e.g., documentation from technical reports and manuals, data from research articles) was examined. When several possible measures were available for a given age group, those with low internal consistency reliability (with coefficients less than .60) or with little evidence of being related to a measure of substance abuse or problem behavior were dropped from further consideration.

Occasionally, instruments without evidence of reliability or validity were included if (1) the instrument's content matched the content of the measures shown in the primary research to be related to substance abuse, and (2) no other measures could be located for that factor and age group.

Each of the two sections (individual and family) presents a variety of instruments that can serve as measures of each factor. Instruments are summarized for different age groups that serve as the target populations of prevention programs. Each entry names the target population of prevention programs, identifies the instrument, summarizes its content, and reviews evidence of its reliability and validity. If evidence of appropriateness for use with different gender and ethnic groups is readily available in manuals or other documents about the instrument, it is summarized. Each summary also discusses the time and special arrangements necessary to use the instrument, its costs, and how it can be obtained.

Note: References marked with () contain reliability or validity information that is summarized in the description of the measure.*

School-Related Attitudes and Behaviors:

Measure 1

Title:

National Youth Survey (NYS)

Ages: grades 7–12

Scales: Academic Aspirations
School Involvement

Author:

Delbert S. Elliott

How To Obtain

Contact Delbert S. Elliott, Institute of Behavioral Science, University of Colorado, Campus Box 483, Boulder, CO 80309. Phone: (303) 492-1266.

Cost

Contact the author.

Ages

The Academic Aspirations and School Involvement scales are appropriate for students in grades 7 through 12.

Content

The NYS has been used in a longitudinal study examining delinquency; substance involvement; and behaviors, experiences, and attitudes related to delinquency and substance abuse among U.S. youth between the ages of 11 and 17. The NYS contains more than 20 scales. The self-report Academic Aspirations and School Involvement scales contain five and three items, respectively. Both scales provide measures of a youth's commitment to school. The Academic Aspirations scale assesses how important doing well in hard subjects or having a high grade point average is to a respondent. The School Involvement scale contains three items that assess the amount of time spent studying during afternoons, evenings, and weekends in an average week. The School Involvement scale measures the time invested in the pursuit of educational goals.

Time and Special Arrangements

NYS uses a face-to-face interview format, but the items of interest can be incorporated into a written survey format. The scales are brief.

Evidence of Reliability

Elliott, Huizinga, and Ageton (1985) reported internal consistency and retest coefficients ranging from .70 to .78 for the Academic Expectations scale. The School Involvement scale had an alpha reliability of .61 (S. Menard, personal communication, April 6, 1994).

Evidence of Criterion-Related Validity

Correlations between the School Involvement scale and substance abuse range from $-.12$ to $-.22$, with a median of $-.16$.

**Evidence of
Appropriateness for
Different Groups**

Although the NYS sample includes both boys and girls and individuals from diverse ethnic backgrounds, evidence regarding the reliability and validity of the above scales for specific ethnic groups or by gender was not reported. The extent to which these measures are valid for both boys and girls or for different ethnic groups is not known.

References

Elliott, D. S., Huizinga, D., & Ageton, S. S. (1985). *Explaining delinquency and drug use*. Beverly Hills, CA: Sage Publications.(*)

School-Related Attitudes and Behaviors:

Measure 2

Title:

What About You (WAY) Forms C and E

Ages: 9–10 (Form E)
11–18 (Form C)

Scales: Attachment to School
Commitment to Education

Authors:

Gary D. Gottfredson and Denise C. Gottfredson

How To Obtain

Contact Gary D. Gottfredson, Ph.D., Gottfredson Associates, Inc., 3239B Corporate Court, Ellicott City, MD 21042. Phone: (410) 461-5530.

Cost Permission must be obtained to use the WAY questionnaire. Assessment booklets, which are reusable for Form C, cost \$.85 to \$1.00 apiece, depending on the quantity ordered. Answer sheets cost \$.08 or \$.09 each. Scoring costs vary depending on the form and the quantity. Form C answer sheets are scanned and scored for \$.25 each. Form E booklets are keyboarded and scored for \$1.45 each.

Ages WAY Form E is appropriate for children in grades 4 and 5. Form C is appropriate for students in grades 6 through 12.

Content WAY is for use with school students in grades 4–12. It contains measures of substance abuse, demographics, and several domains of risk and protection: community, family, school, peer, and individual. Two versions of the survey are available. Form C (184 items) is for youth in grades 6–12. Form E (114 items) is for youth in grades 4–5. The item content is similar in the two versions, but the reading level is lower in the version for younger children. Form C contains both an Attachment to School and a Commitment to Education scale, but Form E measures only Attachment to School because it was not possible to measure attachment and commitment to education separately for these younger youth. The Attachment to School scales (Forms C and E) ask students whether statements such as “I like school” and “I like the principal” are true about themselves. The Commitment to Education scale (Form C) asks respondents how often they turn their homework in on time and whether they expect to complete high school.

Time and Special Arrangements

Administration instructions are provided, along with survey booklets and optically scannable answer sheets. A scoring service is available. The survey takes 50 minutes to complete.

Evidence of Reliability

Gottfredson and Gottfredson (1992b) reported reliability coefficients of .78 and .80 for the Attachment and Commitment scales (Form C), respectively,

and .82 for the Attachment to School scale in Form E. Gottfredson and Gottfredson (1992a) reported 1-year retest coefficients of .53 and .50 for Form C Commitment and Attachment to School.

**Evidence of
Criterion-Related
Validity**

Concurrent correlations between Commitment to Education and various indicators of substance abuse range from $-.15$ to $-.35$, with a median of $-.27$. Concurrent correlations between Attachment to School and substance abuse measures range from $-.13$ to $-.33$, with a median of $-.24$. Correlations with measures of conduct taken from school records—absences, disciplinary referrals, and suspensions—range from $-.09$ to $-.34$ for the Commitment scale (median = $-.23$) and from $-.04$ to $-.20$ for Attachment (median = $-.12$). One-year predictive correlations with these conduct measures range from $-.12$ to $-.32$ (median = $-.22$) for Commitment and from $-.07$ to $-.23$ (median = $-.14$) for Attachment. Correlations between the Form E Attachment to School scale and substance abuse range from $-.11$ to $-.35$, with a median of $-.30$.

**Evidence of
Appropriateness for
Different Groups**

The authors reported similar reliabilities for both forms for boys and girls, both African Americans and European Americans. There were no meaningful gender or race differences in reliability coefficients. Gottfredson and Gottfredson (1992a) also provided evidence of convergent and discriminant validity for the entire population as well as both sexes in African-American and European-American subsamples. Gottfredson (1993) examined the measurement equivalence of the Form C Commitment scale using item-response theory methods and found no evidence of differential item functioning (DIF) for the two sexes and only slight DIF for two items for Black and White students (in opposite directions for the two items). Gottfredson and Koper (1996) showed that Attachment predicts later substance abuse equally well for members of the four subgroups, but Commitment predicts future substance abuse better for European Americans than for African Americans. Additional research examining the reliability and validity of these scales for other ethnic groups would be useful.

References

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School-Related Attitudes and Behaviors:

Measure 3

Ages: grade 4–college

Title:

Scale: N/A

Self-Reported Grades

Author:

N/A

How To Obtain	N/A
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Cost	Questions must be composed, reproduced, and scored by the user.
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Ages	Students in grade 4 through college.
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Content	Students are asked to report their grades in school. A variety of formats have been used. With younger students it is typical to ask whether grades are “mostly A’s,” “mostly B’s,” and so forth (e.g., Gottfredson, 1982). Older youth are sometimes asked to report their grade point average or to estimate their class rank. Sometimes, individuals are asked to report their most recent grades in specific subjects (e.g., Sawyer, Laing, & Houston, 1988).
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Time and Special Arrangements	Information about school performance and school grades can be collected using only a few items (1 to 20), so it can be collected quickly. It appears wise to collect data in a manner that makes reports verifiable in principle, asking, for example, for grades in specific academic subjects.
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Evidence of Reliability	A substantial literature establishes that self-reports of grades converge with information about grades gleaned from official school or college transcripts. Correlations between self-reports and archival records have ranged from .57 to .93, with most correlations in the .80’s.
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Evidence of Criterion-Related Validity	Correlations of self-reported school performance and archival records of grades typically have modest correlations with measures of problem behavior and substance abuse, usually in the mid-.10’s to mid-.20’s.
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Evidence of Appropriateness for Different Groups	Literature reviews and data reported by Maxey and Ormsby (1971) and by Sawyer et al. (1988) imply that substantial differences in convergence of self-report and archival records are seldom found by age, ethnicity, or sex, but that poorer students are less accurate—tending to overreport their grades somewhat. Correlations between self-reported grades and school records imply that students are more accurate at reporting grades in core academic subjects than in electives (Sawyer et al., 1988).
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Peer Influence:

Measure 4

Title:

American Drug and Alcohol Survey (ADAS)

Ages: grades 4–6 (child)
7–12 (adol)

Scale: Peer Drug Associations

Authors:

E. R. Oetting, F. Beauvais, and R. Edwards

How To Obtain

Contact RMBSI, Inc., 419 Canyon Avenue, Suite 316, P.O. Box 1066, Fort Collins, CO 80522. Phone: (800) 447-6354.

Cost The ADAS costs \$1 per copy with discounts for quantities greater than 800. Results are summarized in a report for \$200 for the adolescent form and \$100 for the children's form.

Ages The adolescent form is intended for youth in grades 7 through 12, and the children's form is for youth in grades 4 through 6.

Content The ADAS is available in two versions: the children's form (39 items) and the adolescent form (57 items). The Peer Drug Associations (PDA) scale is a 17-item scale that asks about the number of friends using substances, whether friends have asked the youth to try substances, how strongly the youth would try to prevent friends from using substances, and how strongly friends would try to stop the youth's substance abuse. Sample items are "How many of your friends get drugs?" "How often have your friends asked you to use cocaine?" "How much would your friends try to stop you from using downers?" and "How much would you try to stop your friends from using cocaine?" The children's form contains similar questions with reference to substances (i.e., alcohol, tobacco, marijuana).

Time and Special Arrangements

Contact RMBSI, Inc. (address below) for information and administration instructions. The ADAS takes 20 to 30 minutes to complete.

Evidence of Reliability

Reliability coefficients of .91 and .85 have been obtained using two different adolescent samples—one predominantly White (87 percent) and one Native American (100 percent).

Evidence of Criterion-Related Validity

Correlations with substance abuse range from .44 to .74, with a median of .66.

**Evidence of
Appropriateness for
Different Groups**

Reliability and validity of the PDA scale have been assessed using predominantly White and predominantly Native-American samples. Alpha coefficients were similar for both populations. In one study, a higher correlation of PDA scores with self-reported substance abuse was found for Whites than for Native-American youths, but the correlation was substantial for both groups. Reliability and validity evidence has not been reported for separate sex or other ethnic groups.

References

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Peer Influence:
Measure 5

Title:

**What About You (WAY),
Forms C and E**

Ages: 9–10 (Form E)
11–18 (Form C)

Scales: Positive Peer Influence
Peer Drug Models

Authors:

Gary D. Gottfredson and Denise C. Gottfredson

How To Obtain	Contact Gary D. Gottfredson, Ph.D., Gottfredson Associates, Inc., 3239B Corporate Court, Ellicott City, MD 21041. Phone: (410) 461-5530.
Cost	Permission must be obtained to use the WAY questionnaire. Assessment booklets, which are reusable for Form C, cost \$.85 to \$1.00 apiece, depending on the quantity ordered. Answer sheets cost \$.08 or \$.09 each. Scoring costs vary, depending on the form and the quantity. Form C answer sheets are scanned and scored for \$.25 each. Form E booklets are keyboarded and scored for \$1.45 each.
Ages	Form C is intended for use with students in grades 6 through 12 (ages 11 through 18), and Form E is intended for use with students in grades 4 and 5 (ages 9 and 10) or for poor readers.
Content	WAY is a self-report questionnaire that assesses a variety of individual, peer, and family risk factors for problem behavior. Question formats include true-false and Likert-type scales. WAY is available in two forms: a 184-item Form C for adolescents and a 114-item Form E intended for children and poor readers. The Positive Peer Influence scale has seven items in Form C and 12 items in Form E. True-false items such as “My friends often try to get me to do things the teacher doesn’t like” and “Most of my friends think getting good grades is important,” are typical of both the Forms C and E Positive Peer Influence scale. Examples of items from the Peer Drug Models scale (Forms C and E) are “During the last year, how many of your friends have done each of the following things . . . Used marijuana? Sold drugs?” The Peer Drug Models scale is composed of 8 items in Form E and 10 items in Form C.
Time and Special Arrangements	Administration instructions are provided, along with survey booklets and optically scannable answer sheets. A scoring service is available. The survey takes 50 minutes to complete.
Evidence of Reliability	For the Positive Peer Influence subscale, the estimates of internal consistency range from .60 to .66 for Form C and from .70 to .76 for Form E. Retest reliability estimates of .40 to .47 were obtained for Form C and .55 for Form E.

For the Peer Drug Models subscale, estimates of internal consistency range from .83 to .87 for Form C and from .83 to .88 for Form E. Retest estimates for Peer Drug Models ranged from .48 to .62 for Form C, and the estimate was .72 for Form E.

**Evidence of
Criterion-Related
Validity**

For Positive Peer Influence, concurrent correlations between the Form C scale and substance abuse range from $-.09$ to $-.28$, with a median of $-.22$. Correlations with school records (suspensions, disciplinary referrals, and absences) and a teacher rating of problem behavior range from $-.02$ to $-.24$, with a median of $-.12$. One-year predictive correlations with school records and a teacher rating of problem behavior range from $.01$ to $-.26$, with a median of $-.12$. Correlations between the Form E scale and substance abuse range from $-.07$ to $-.43$, with a median of $-.37$.

For Peer Drug Models, concurrent correlations between the Form C scale and substance abuse range from $.34$ to $.67$, with a median of $.48$. Correlations with school records and a teacher rating of problem behavior range from $.00$ to $.35$, with a median of $.14$. One-year predictive correlations with school records and teacher-rated problem behavior range from $-.02$ to $.32$, with a median of $.14$. Correlations between the Form E scale and substance abuse range from $.33$ to $.72$, with a median of $.66$.

**Evidence of
Appropriateness for
Different Groups**

Reliability and validity for Form E have been reported for males and females but have not been reported for different ethnic groups. However, this evidence has been reported in Form C for the following groups: African-American boys, African-American girls, European-American boys, and European-American girls. The reliability coefficients were similar for boys and girls on the Form E scales, and criterion-related validity coefficients for Form E were similar for boys and girls with one exception.

For Form C, reliability and retest coefficients were similar for African-American and European-American males and females for both the Positive Peer Influence and Peer Drug Models scales. Correlations between substance abuse and the Peer Drug Models scale showed a moderate to high relationship for each group, with the lowest association for African-American females. Validity of the Positive Peer Influence scale was assessed using external criteria and showed correlations in the expected direction for all subgroups, with the lowest correlations among African-American males. Other analyses (Gottfredson & Koper 1996, 1997) imply that Positive Peer Influence does not predict substance abuse for African Americans as well as for European Americans. Also, the Peer Drug Models scale does not predict frequency of substance abuse as well for African-American females as for other groups.

- References**
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- Gottfredson, D. C., & Koper, C. S. (1997). Race and sex differences in the measurement of risk for drug use. *Journal of Quantitative Criminology* 13, 325–347.
- Gottfredson, G. D., & Gottfredson, D. C. (1992). *Development and applications of theoretical measures for evaluating drug and delinquency prevention programs*. Paper presented at the annual meeting of the American Society of Criminology, New Orleans.(*)
- Gottfredson, G. D., & Gottfredson, D. C. (1992). *What About You Forms C and E, research editions: Supplementary information*. Ellicott City, MD: Gottfredson Associates, Inc.(*)

Peer Influence:

Measure 6

Title:

Survey of Youth

Ages: 12–18

Scale: Differential Peer
Associations

Author:

Ronald L. Akers

How To Obtain

Contact Ronald L. Akers, Ph.D., Department of Sociology, P.O. Box 115950, University of Florida, Gainesville, FL 32611-5950. Phone: (352) 392-1025, E-mail: rla@soc.ufl.edu

Cost Users must compose, reproduce, and score materials themselves.

Ages These scales are appropriate for early to late adolescent youth (grades 7 through 12; ages 12 through 18).

Content Several scales made up of three items measure how many of a youth's best friends, friends with whom they associate most often, and friends whom they have known for the longest time use each of a variety of substances. Items include "How many of your *best friends* use [alcohol] at least sometimes?" Response categories are "none or almost none," "less than half," "more than half," and "almost all."

Time and Special Arrangements Each Differential Peer Association scale is made up of three items and should take only a few minutes to complete.

Evidence of Reliability High item-to-scale uncorrected correlations for the alcohol and marijuana scales were reported by Akers, Krohn, Lanza-Kaduce, and Radosevich, (1979), but no information was reported for the items relating to stimulants, depressants, or stronger substances.

Evidence of Criterion-Related Validity The Differential Peer Association scale correlated .68 with alcohol use and .79 with marijuana use.

Evidence of Appropriateness for Different Groups The source document provided data from a sample of male and female students from Midwestern States.

References Akers, R. L., Krohn, M. D., Lanza-Kaduce, L., & Radosevich, M. (1979). Social learning and deviant behavior: A specific test of a general theory. *American Sociological Review* 44, 636–655.(*)

Peer Influence:

Measure 7

Title:

Communities That Care Youth Survey

Ages: 11–18

Scales: Interaction with Antisocial
Peers
Friends' Use of Drugs

Authors:

Michael Arthur, John A. Pollard, J. David Hawkins, and
Richard F. Catalano

How To Obtain

Contact Customer Service, Developmental Research and Programs, Inc., 130 Nickerson St., #107, Seattle, WA 98119. Phone: (206) 286-1805, Fax: (206) 286-1462.

Cost Cost is \$1.80 per survey form. There are additional costs (\$300–\$625) for analysis and report generation. For an additional fee, the survey can be customized to better meet individual users' needs.

Ages The survey is intended for ages 11 through 18 (grades 6–12).

Content The Communities That Care Youth Survey contains 201 items. It includes scales measuring substance abuse; demographic characteristics; and community, family, school, peer, and individual factors related to substance abuse. The six-item Interaction with Antisocial Peers scale contains the following items: "Think of your *four best friends* (the friends you feel closest to). In the past year, how many of your best friends have: been suspended from school? ... Carried a handgun?" The four-item Friends' Use of Drugs scale contains items such as the following: "Think of your *four best friends* (the friends you feel closest to). In the past year, how many of your best friends have: smoked cigarettes? used marijuana?" Response categories for both scales range from "none" to "four."

Time and Special Arrangements

The survey is designed to be administered in a single class period of 45 minutes to 1 hour. Administration instructions are provided by Developmental Research and Programs, Inc. (DRP). The survey is provided on an optically scannable form. Completed surveys are returned to DRP for scoring, development of the data base, analysis, and report generation. Users are responsible for administration and return of the completed surveys to DRP.

Evidence of Reliability

The authors report an alpha of .86 for the Interaction with Antisocial Peers scale and .86 for the Friends' Use of Drugs scale.

Evidence of Criterion-Related Validity

Correlations between the Interaction with Antisocial Peers scale and substance abuse range from .24 to .43, with a median of .37. Correlations between the Friends' Use of Drugs scale and substance abuse range from .34

to .60, with a median of .51. Antisocial behavior correlated .54 with Interaction with Antisocial Peers and .32 with Friends' Use of Drugs.

**Evidence of
Appropriateness for
Different Groups**

The data presented above were obtained from a sample of mostly White adolescents. Detailed analysis of survey appropriateness was not attempted for specific ethnic or racial populations.

References

This is a recently developed instrument. A manual is not yet available. This account is based on tabulations and listings provided by Michael Arthur through personal communication (1995). Contact John Pollard with questions at (206) 286-1805.

Conduct Problems:

Measure 8

Ages: 4–18 (CBCL)
5–18 (TRF)

Title:

Child Behavior Checklist (CBCL) and Teacher's Report Form (TRF)

Scale: Externalizing

Author:

Thomas M. Achenbach

How To Obtain

Contact Child Behavior Checklist, 1 S. Prospect Street, Burlington, VT 05401-3456. Phone: (802) 656-8313, Fax: (802) 656-2602.

Cost

CBCL or TRF report forms cost \$10 for a package of 25. Profile forms for boys or girls on the CBCL or TRF are \$10 for a package of 25. A scoring template is \$7. Manuals cost \$25 for either the CBCL or the TRF. A scoring program for IBM or Apple for either CBCL or TRF costs \$135. A Cross-Informant Scoring Program for either CBCL or TRF costs \$295. (CBCL and TRF programs are not needed when this program is used.)

Ages

The CBCL can be used to assess children aged 4–18. The TRF is designed for use with school-aged children (5–18 years old).

Content

The CBCL is a 113-item written parent or observer report of child behavior. Responses to the items range from 0 ("Not true") to 2 ("Very true or often true"). The Externalizing scale contains 33 items, including "Argues a lot," "Disobedient at school," "Sets fires," and "Doesn't seem to feel guilty after misbehaving."

The TRF contains the same number of items and the same response format as the CBCL but is meant to be filled out by a teacher or other school personnel familiar with the child. The externalizing scale contains 34 items, most of which can also be found in the CBCL. Examples of items are "Lying or cheating" and "Threatens people."

Time and Special Arrangements

The average time for completion of the entire checklist is 15–17 minutes. Both the CBCL and TRF can be scored manually or by computer. The CBCL can be filled out by a parent or parent surrogates. The instrument should be administered to the respondent by someone who is familiar with it and who can answer questions. Likewise, the TRF can be completed by a teacher who has known the child for at least 2 months, but it should be administered by someone familiar with the instrument.

Evidence of Reliability	The Externalizing scale had an alpha of .93 and interparent correlations ranging from .44 to .86. Retest correlations ranged from .91 to .95 for a 1-week interval, from .86 to .87 for a 1-year interval, and from .65 to .86 for a 2-year interval. Four- and six-year retest correlations were .63 and .55, respectively. Reliability evidence for the TRF was reported in the manual (Achenbach, 1991b). Alphas ranged from .95 to .96, and interrater correlations ranged from .45 to .79. Fifteen-day retest correlations ranged from .86 to .97; retest correlations were .77 for a 2-month interval and .68 for a 4-month interval.
Evidence of Criterion-Related Validity	Correlations between the CBCL Externalizing scale and two other measures of problem behavior are .86 and .88. These two measures of problem behavior and the CBCL were filled out by the same parent at the same sitting, so the criterion is not independent of the CBCL scores. The correlation between the TRF Externalizing scale and another teacher-rated problem behavior scale rated by the same individuals was .83.
Evidence of Appropriateness for Different Groups	The CBCL and TRF manuals reported tests for ethnic and socioeconomic status (SES) differences for all items and scales. Ethnic differences were generally negligible; lower SES children tended to score slightly higher. Reliability and validity evidence was not reported separately for different subgroups, but both instruments have been used with diverse populations.
References	<p>Achenbach, T. M. (1991a). <i>Manual for the Child Behavior Checklist/4-18 and 1991 profile</i>. Burlington, VT: University of Vermont, Department of Psychiatry.(*)</p> <p>Achenbach, T. M. (1991b). <i>Manual for the Teacher's Report Form and 1991 profile</i>. Burlington, VT: University of Vermont, Department of Psychiatry.(*)</p> <p>Stanger, C., & Lewis, M. (1993). Agreement among parents, teachers, and children on internalizing and externalizing behavior problems. <i>Journal of Clinical Child Psychology</i>, 22(1), 107–115.(*)</p> <p>Verhulst, F. C., & Van der Ende, J. (1992). Six-year stability of parent-reported problem behavior in an epidemiological sample. <i>Journal of Abnormal Child Psychology</i>, 20(6), 595–610.(*)</p>

Conduct Problems:

Measure 9

Title:

Conners' Rating Scales

Author:

C. Keith Conners

Ages: 3–17

Scale: Conduct Problem

How To Obtain

Contact Multi-Health Systems, 908 Niagara Falls Boulevard, North Tonawanda, NY 14120-2060. Phone: (800) 456-3003, Fax: (416) 424-1736.

Cost Conners' Parent and Teacher Rating Scales Manual costs \$27; a pack of 25 self-scoring forms, CPRS-48, \$20; a pack of 25 self-scoring forms, CTRS-39, \$20; computer software, IBM (50 uses), \$145.

Ages The Conners' Rating Scales are designed for describing individuals aged 3 to 17.

Content The Conners' Rating Scales are self-scored reports of child behavior. There are parent and teacher forms of the Conners' Rating Scales; the CTRS-39 is the 39-item teacher version, and the CPRS-48 is the 48-item parent version. Both contain a Conduct Problem scale, which is 8 items long in the CPRS-48 and 13 items long in the CTRS-39. Examples of items are "Quarrelsome," "Destructive," and "Lies."

Time and Special Arrangements The CPRS-48 can be administered in approximately 20 minutes, and the CTRS-39 can be administered in about 15 minutes. Both forms can be scored manually; the answer sheet is a pressure-sensitive, self-scoring form. A computer version containing short and long versions of the parent and teacher forms is also available.

Evidence of Reliability The Conduct Problem scale of the CTRS-39 had alphas ranging from .91 to .94, 1-year retest correlations ranging from .11 to .63, and interrater correlations ranging from .33 to .66. The Conduct Problem scale of the CPRS-48 had interrater correlations ranging from .33 to .57.

Evidence of Criterion-Related Validity A correlation between the CTRS-39 and parent rating of problem behavior of .54 has been reported. Correlations between the CPRS-48 and other parent ratings of problem behavior range from .02 to .34, with a median of .20, when filled out by the same parent, and from .15 to .38, with a median of .17, when filled out by the other parent.

**Evidence of
Appropriateness for
Different Groups**

The manual did not provide demographic information for the samples on which the reported reliability and validity evidence is based.

References

- Cohen, M., & Hynd, G. (1986). The Conners' Teacher Rating Scale: A different factor structure with special education children. *Psychology in the Schools, 23*, 13–23.(*)
- Conners, C. K. (1990). *Conners' rating scales manual*. North Tonawanda, NY: Multi-Health Systems, Inc.(*)
- Glow, R. A., Glow, P. H., & Rump, E. E. (1982). The stability of child behavior disorders: A one year test-retest study of Adelaide versions of the Conners' Teacher and Parent Rating Scales. *Journal of Abnormal Child Psychology, 10*(1), 33–59.(*)
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- Schaughency, E. A., & Fagot, B. I. (1993). The prediction of adjustment at age 7 from activity level at age 5. *Journal of Abnormal Child Psychology, 21*(1), 29–50.(*)
- Trites, R. L., Blovin, A. G., & Laprade, K. (1982). Factor analysis of the Conners' Teacher Rating Scale based on a large normative sample. *Journal of Consulting and Clinical Psychology, 50*(5), 615–623.(*)

Conduct Problems:

Measure 10

Title:

Youth in Transition Survey (YIT)

Author:

Jerald G. Bachman

Ages: grades 10—one year after
high school

Scale: Rebellious Behavior in
School

How To Obtain

Contact Jerald G. Bachman, Ph.D., Institute for Social Research, University of Michigan, Ann Arbor, MI 48106. Phone: (313) 763-5043.

Cost Users must compose, reproduce, and score the scale themselves.

Ages This instrument was used with students in 10th grade who were retested several times until one year after finishing high school.

Content The YIT Survey is a self-report written instrument. The Rebellious Behavior in School scale asks the respondent to report how often he or she performs 13 different behaviors. Response choices are 1 to 5, with 1 meaning “almost always” and 5 meaning “never.” Examples of items are “How often do you cheat on tests?” and “How often do you argue with your teachers?”

Time and Special Arrangements

The Rebellious Behavior in School scale can be administered as part of a paper-and-pencil questionnaire. The 10 to 13 questions will take only a few minutes for most students to complete.

Evidence of Reliability

The original YIT version had alphas ranging from .82 to .94 for a sample of high school boys.

Evidence of Criterion-Related Validity

Concurrent correlations between the Rebellious Behavior scales range from .22 to .47. The scale had correlations ranging from .06 to .39 with school records (absences, suspensions, and disciplinary referrals). One-year predictive correlations with school records ranged from .02 to .32.

Evidence of Appropriateness for Different Groups

The YIT sample was all male and mostly White.

References

- Bachman, J. G. (1975). *Youth in transition: Documentation manual* (Vol. II, 2nd ICPSR ed.). Ann Arbor, MI: Inter-University Consortium for Political and Social Research.(*)
- Gottfredson, D. C. (1987). An evaluation of an organization development approach to reducing school disorder. *Evaluation Review*, 11, 739–763.(*)
- Gottfredson, D. C., Gottfredson, G. D., & Hybl, L. G. (1993). Managing adolescent behavior: A multiyear, multischool study. *American Educational Research Journal*, 30, 179–215.(*)
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- Johnston, L. D., O'Malley, P. M., & Eveland, L. K. (1978). Drugs and delinquency: A search for causal connections. In D. B. Kandel (Ed.), *Longitudinal research on drug use: Empirical findings and methodological issues* (pp. 137–156.) Washington, DC: Hemisphere Publishing Corporation.(*)

Conduct Problems:

Measure 11

Title:

Rutter Child Scale, Form B

Ages: 6–13

Scale: Antisocial Behavior

Author:

Michael Rutter

How To Obtain

The scale is part of the *Child Psychology Portfolio* edited by Irene Sclare and available from NFER-NELSON, Darville House, 2 Oxford Road East, Windsor, Berks SL4 1DF, United Kingdom 44-01753 827249, www.nfer-nelson.co.uk.

Cost £375

Ages The instrument has been used to rate children ages 6–13.

Content The Rutter Child Scale, Form B, summarizes teacher reports of child behavior. Responses to items range from 0 (“Does not apply”) to 2 (“Certainly applies”). The Antisocial subscale contains six items. Examples of items are “Often destroys own or others’ belongings” and “Is often disobedient.”

Time and Special Arrangements The Rutter Child Scale, Form B, should be filled out by a teacher who is familiar with the child being rated.

Evidence of Reliability Reliability evidence for the Antisocial Behavior scale has been reported in a number of studies (summarized in Elander & Rutter, 1996). An alpha of .83 was found for the scale for a sample of 7-year-old children. The 3- to 5-month retest coefficient was .72 when the same teacher rated the child on each occasion and .62 with two different raters. The 2-year retest correlation was .46, and an interrater correlation of .72 has been reported.

Evidence of Criterion-Related Validity No information was found about the association of this scale with measures of substance abuse. Although the literature establishes association between total scores on the Rutter Child Scale and membership in groups associated with problem behavior (kappas calculated from data reported in Elander and Rutter [1996] range from .21 to .52, with a median of .44), criterion-related validity evidence has not been reported for the Antisocial Behavior subscale.

Evidence of Appropriateness for Different Groups The Rutter scales have been translated and used in many countries, including England, India, Japan, Uganda, Nigeria, China, New Zealand, France, Jamaica, Mauritius, Norway, Sweden, Finland, Italy, and Greece. Some

evidence suggests that different scoring systems may be appropriate for different groups (Elander & Rutter 1996).

- References** Elander, J., & Rutter, M. (1996). Use and development of the Rutter Parents' and Teachers' Scales. *International Journal of Methods in Psychiatric Research*, 6(2), 63–78.(*)

Conduct Problems:

Measure 12

Ages: 5–18

Scale: Conduct Disorder

Title:

Revised Behavior Problem Checklist (RBPC)—PAR Edition

Authors:

Herbert C. Quay and Donald R. Peterson

How To Obtain	Contact Psychological Assessment Resources, P.O. Box 998, Odessa, FL 33556. Phone: (800) 383-6595, Fax: (800) 727-9329.
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Cost	Manual, \$22; test booklets (25), \$38; profile sheets (25), \$9.
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Ages	The RBPC can be used with children and adolescents ages 5–18.
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Content	The RBPC calls for an observer (e.g., parent, teacher) to rate child behavior. Item responses range from 0 to 2, with 0 meaning that the problem behavior is never or rarely exhibited by the child. The Conduct Disorder scale contains 22 items. Examples of these items are “Has temper tantrums,” “Deliberately cruel to others,” and “Impertinent; talks back.”
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Time and Special Arrangements	The RBPC can be administered in about 10 minutes and scored in 5 minutes. It should be filled out by a parent, teacher, clinician, or other observer.
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Evidence of Reliability	Alphas range from .92 to .95, and interrater correlations range from .13 to .85, with a median of .36. Retest correlations range from .52 to .81 for a 5-month interval and from .27 to .46 for a 1-year interval.
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Evidence of Criterion-Related Validity	Correlations with substance abuse range from .07 to .19, with a median of .10; correlations with other ratings of problem behavior range from .68 to .95, with a median of .79; and correlations with ratings of aggression range from .44 to .88, with a median of .72.
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Evidence of Appropriateness for Different Groups	The factor analyses, reliability, and validity evidence reported in the manual were taken from a number of samples varying in racial, sex, and socioeconomic composition. Most samples consisted of African-American and European-American youth, although a small number were made up mostly or completely of European-American youth. Information was not presented separately for the subpopulations. Other studies have reported reliability information separately by sex and ethnicity, with no remarkable pattern of differences. Correlations with substance abuse were also similar across sex and ethnic groups.
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References

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- Cutchen, M. A., & Simpson, R. G. (1993). Interrater reliability among teachers and mental health professionals when using the Revised Behavior Problem Checklist. *Journal of Psychoeducational Assessment*, 11, 4-11.(*)
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- Gottfredson, G. D., & Gottfredson, D. C. (1992). *What About You Forms C and E, research editions: Supplementary information*. Ellicott City, MD: Gottfredson Associates, Inc.(*)
- Hogan, A. E., Quay, H. C., Vaughn, S., & Shapiro, S. K. (1989). Revised Behavior Problem Checklist: Stability, prevalence, and incidence of behavior problems in kindergarten and first-grade children. *Psychological Assessment*, 1(2), 103-111.(*)
- Kelly, E. J., & Van Vactor, J. C. (1992). Distinguishing between conduct-problem and emotionally disturbed students in elementary school: A five-instrument discriminant analysis. *Psychological Reports*, 70, 311-319.(*)
- Mattison, R. E., Bagnato, S. J., & Strickler, E. (1987). Diagnostic importance of combined parent and teacher ratings on the Revised Behavior Problem Checklist. *Journal of Abnormal Child Psychology*, 15(4), 617-628.(*)
- Quay, H. C., & Peterson, D. R. (1996). *Revised Behavior Problem Checklist: PAR edition, professional manual*. Odessa, FL: Psychological Assessment Resources.
- Simpson, R. G. (1989). Agreement among teachers in using the Revised Behavior Problem Checklist to identify deviant behavior in children. *Behavioral Disorders*, 14(3), 151-156.(*)
- Simpson, R. G., and Halpin, G. (1986). Agreement between parents and teachers in using the Revised Behavior Problem Checklist to identify deviant behavior in children. *Behavioral Disorders*, 12, 54-59.(*)

Conduct Problems:

Measure 13

Ages: 11–18

Title:

Scale: Early Initiation of Problem Behavior

Communities That Care Youth Survey

Authors:

Michael Arthur, John A. Pollard, J. David Hawkins, and
Richard F. Catalano

How To Obtain	Contact Customer Service Developmental Research and Programs, Inc., 130 Nickerson St., #107, Seattle, WA 98119. Phone: (206) 286-1805, Fax: (206) 286-1462.
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Cost	Cost is \$1.80 per survey form. There are additional costs (\$300–\$625) for analysis and report generation. For an additional fee, the survey can be customized to better meet individual users' needs.
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Ages	The instrument is intended for ages 11 through 18 (grades 6–12).
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Content	The Communities That Care Youth Survey contains 201 items. It includes scales measuring substance abuse; demographic characteristics; and community, family, school, peer, and individual factors related to substance abuse. The Early Initiation of Problem Behavior scale is made up of eight items that ask respondents how old they were when, for example, they first smoked marijuana or got suspended from school. The number of response choices available depends on the age of the respondent; that is, for 11-year olds, it is a three-point scale (“never have,” “10 or younger,” and “11”). For 13-year-olds, it is a five-point scale.
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Time and Special Arrangements	The survey instrument is designed to be administered in a single class period of 45 minutes to 1 hour. Administration instructions are provided by Developmental Research and Programs, Inc. (DRP). The survey is provided on an optically scannable form. Completed surveys are returned to DRP for scoring, development of the data base, analysis, and report generation. The survey organizer is responsible for administration and return of the completed surveys to DRP.
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Evidence of Reliability	The authors reported an alpha of .75 for the Early Initiation of Problem Behavior scale.
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Evidence of Criterion-Related Validity	Correlations between the Early Initiation of Problem Behavior scale and substance abuse range from .21 to .52, with a median of .35.
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**Evidence of
Appropriateness for
Different Groups**

The data presented above were from a primarily White adolescent population. Survey appropriateness has not been assessed for specific ethnic or racial populations.

References

Manuals or other source documents are not available for this newly developed instrument. Contact John A. Pollard with questions at (206) 286-1805.

Impulsivity/Low Self-Control:

Measure 14

Title:

Impulsiveness-7

Ages: adult

Scale: Impulsivity

Authors:

Sybil B. G. Eysenck, Paul R. Pearson, G. Easting, and John F. Allsopp

How To Obtain	EDITS, P.O. Box 7234, San Diego, CA 92167. Phone: (619)488-1666, Fax: (619) 226-1666, Attn: Dr. Lisa Lee.
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Cost	Contact the publisher.
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Ages	The Impulsiveness-7 is for use with adults.
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Content	The Impulsiveness-7 is a self-report questionnaire that consists of three scales: Impulsivity, Adventurousness, and Empathy. The Impulsivity scale contains 19 yes/no questions about the tendency to act without thinking. Some specific items are "Do you usually think carefully before doing anything?" "Do you prefer to 'sleep on it' before making decisions?" and "Do you often change your interests?"
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Time and Special Arrangements	Administration instructions are provided in the manual available from the publisher. Hand-scoring keys can also be obtained from the publisher.
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Evidence of Reliability	The Impulsiveness-7 scale had alphas ranging from .55 to .84 and a 1-month retest correlation of .76.
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Evidence of Criterion-Related Validity	Correlations with substance abuse range from .10 to .29, with a median of .11. The scale also correlated .54 with a self-rating of aggression.
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Evidence of Appropriateness for Different Groups	The samples used in the source document were male and female adults from England. Eysenck, Daum, Schugens, and Diehl (1990) demonstrated comparable measurement properties for a German sample of adults, both male and female.
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References

- Corrulla, W. J. (1988). A further psychometric investigation of the Sensation Seeking Scale Form-V and its relationship to the EPQ—R and the I.7 Impulsiveness Questionnaire -700 A. *Personality and Individual Differences*, 9, 277–287.(*)
- Eysenck, S. B., Daum, I., Schugens, M. M., & Diehl, J. M. (1990). A cross-cultural study of impulsiveness, venturesomeness and empathy: Germany and England. *Zeitschrift für Differentielle und Diagnostische Psychologie*, 11(4), 209–213.
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- Luengo, M. A., Carrillo-de-la-Pena, M. T., & Otero, J. M. (1991). The components of impulsiveness: A comparison of the I.7 Impulsiveness Questionnaire and the Barratt Impulsiveness Scale. *Personality and Individual Differences*, 12, 657–667.(*)
- Nagoshi, C. T., Walter, D., Muntaner, C., & Haertzen, C. A. (1992). Validation of the Tridimensional Personality Questionnaire in a sample of male drug users. *Personality and Individual Differences*, 13, 401–409.(*)
- Ruch, W., Angleitner, A., & Strelau, J. (1991). The Strelau Temperament Inventory—revised (STI-R): Validity studies. *European Journal of Personality*, 5, 287–308.(*)

Impulsivity/Low Self-Control:

Measure 15

Title:

Junior I⁶

Ages: 8–15

Scale: Impulsivity

Authors:

Sybil B. G. Eysenck, G. Easting, and P. R. Pearson

How To Obtain

Contact Sybil B. G. Eysenck, Department of Psychology, Institute of Psychiatry, DeCrespigny Park, Denmark Hill, London SE5 8AF, United Kingdom. Phone: 44(171)733-8129. (Note: Scale is contained in Eysenck et al., 1984.)

Cost

Price and availability information can be obtained from the author.

Ages

The Junior I⁶ is for use with children ages 8–15.

Content

The Junior I⁶ is a version of the Impulsiveness-7 designed for use with children and adolescents. It contains the scales Impulsivity, Venturesomeness, and Empathy. The Impulsivity scale contains 23 items with a yes/no response format. Item content is close to that of the Impulsiveness-7 but includes some items that refer specifically to school and schoolwork and to a need for excitement and stimulation. Examples of items are “Would you enjoy gambling?” “Do you usually think carefully before doing anything?” “Do you get very annoyed if someone keeps you waiting?” and “Do you often do things on the spur of the moment?”

Time and Special Arrangements

Administration instructions are not given in the source document.

Evidence of Reliability

The source document (Eysenck, Easting, & Pearson, 1984) reported reliabilities for the Junior I⁶ for three different samples. The reliability coefficients for the Impulsiveness scale ranged from .74 to .78 for boys and from .73 to .83 for girls. Reliability coefficients detailed by age for one sample ranged from .68 to .78 for boys and .71 to .84 for girls.

Evidence of Criterion-Related Validity

No information about correlations with substance abuse was reported in the source document, but the Junior I⁶ is based on the Impulsiveness-7, which has been shown to correlate with substance abuse.

**Evidence of
Appropriateness for
Different Groups**

The sample used in the source document was made up of English schoolchildren aged 7–15. A demographic description of the sample is not given. Alphas were similar across age and sex. Saklofske and Eysenck (1983) demonstrated comparable reliability and intercorrelations for a sample of Canadian boys and girls.

References

- Eysenck, S. B., Easting, G., & Pearson, P. R. (1984). Age norms for impulsiveness, venturesomeness and empathy in children. *Personality and Individual Differences*, 5, 315–321.(*)
- Eysenck, S. B., & Jamison, R. N. (1986). A cross-cultural study of personality: American and English children. *Journal of Social Behavior and Personality*, 1(2), 199–207.(*)
- Saklofske, D. H., & Eysenck, S. B. (1983). Impulsiveness and venturesomeness in Canadian children. *Psychological Reports*, 52, 147–152.(*)

Impulsivity/Low Self-Control:

Measure 16

Ages: adult

Title:

Scale: Dysfunctional Impulsivity

Functional and Dysfunctional Impulsivity Scale

Author:

Scott J. Dickman

How To Obtain

Contact Scott J. Dickman, Department of Psychology, University of Massachusetts–Dartmouth, 285 Old Westport Rd., North Dartmouth, MA 02747-2300. Phone: (508) 999-8440. (Note: Questions are included in Dickman, 1990.)

Cost

Price and availability information can be obtained from the author.

Ages

The scale was designed for use with adults.

Content

Dysfunctional Impulsivity is a 12-item self-report scale. Examples of the items are “I often make up my mind without taking the time to consider the situation from all angles” and “Before making any important decisions, I carefully weigh the pros and cons.”

Time and Special Arrangements

The Functional and Dysfunctional Impulsivity scale can be administered to groups in approximately 15 minutes.

Evidence of Reliability

Alphas are .84 and .85.

Evidence of Criterion-Related Validity

Correlations between the Dysfunctional Impulsivity scale and self-reported delinquency range from .27 to .40, with a median of .36.

Evidence of Appropriateness for Different Groups

Development of the scale was based on data from a sample of college undergraduate men and women. Demographic information on the sample was not reported in the source document.

References

Dickman, S. J. (1990). Functional and dysfunctional impulsivity: Personality and cognitive correlates. *Journal of Personality and Social Psychology*, 58(1), 95–102.(*)

Heaven, P. C. L. (1993). Personality predictors of self-reported delinquency. *Personality and Individual Differences*, 14, 67–76.(*)

Impulsivity/Low Self-Control:

Measure 17

Title:

Self-Control Rating Scale (SCRS)

Ages:	elementary grades
Scale:	Self-Control Rating

Authors:

Phillip C. Kendall and Lance E. Wilcox

How To Obtain	Contact Phillip C. Kendall, Ph.D., Department of Psychology, Temple University, Philadelphia, PA 19122. Phone: (215) 204-1558. Fax: (215) 204-5539.
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Cost	Price and availability information can be obtained from the author.
Ages	SCRS is used with elementary school children.
Content	SCRS is a teacher rating of a child’s level of self-control. It contains 33 items with response choices on a seven-point continuum. For each item, a 1 indicates maximum self-control and 7 indicates maximum impulsiveness. Examples of items are “Does the child interrupt inappropriately in conversations with peers, or wait his or her turn to speak?” “When reprimanded, does the child answer back inappropriately?” and “Would you describe this child as more careful or careless?” Descriptive anchors are provided for each end of the scale.
Time and Special Arrangements	SCRS should be filled out by a teacher who knows the child well.
Evidence of Reliability	The source document (Kendall & Wilcox, 1979) reported an alpha of .98 and a 3- to 4-week retest coefficient of .84 for the SCRS. More important, inter-rater correlations of .66 have been reported for two samples.
Evidence of Criterion-Related Validity	Kendall and Wilcox (1979) reported a correlation between the SCRS and behavioral ratings of time spent off task and out of seat of .28. Kendall, Zupan, and Braswell, (1981) reported high (.81) correlations between the SCRS and teacher ratings of externalizing problem behaviors. The scale has been found to be sensitive to changes in self-control behavior produced in experiments (Kendall & Braswell, 1982).
Evidence of Appropriateness for Different Groups	The SCRS has been used with predominantly White middle-class groups and with African-American children. Results of experiments have been similar for these groups.

References

- Bloomquist, M. L., August, G. J., & Ostrander, R. (1991). Effects of a school-based cognitive-behavioral intervention for ADHD children. *Journal of Abnormal Child Psychology*, 19(5), 591–605.(*)
- Fehlings, D. L., Roberts, W., Humphries, T., & Dawe, G. (1991). Attention Deficit Hyperactivity Disorder: Does cognitive behavioral therapy improve home behavior? *Journal of Developmental and Behavioral Pediatrics*, 12(4), 223–228.(*)
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- Frentz, C., Gresham, F. M., & Elliott, S. N. (1991). Popular, controversial, neglected, and rejected adolescents: Contrasts of social competence and achievement differences. *Journal of School Psychology*, 29, 109–120.(*)
- Glick, B., & Goldstein, A. P. (1987). Aggression replacement training. *Journal of Counseling and Development*, 65, 356–362.(*)
- Kendall, P. C., & Braswell, L. (1982). Cognitive-behavioral self-control therapy for children: A components analysis. *Journal of Consulting and Clinical Psychology*, 50(5), 672–689.(*)
- Kendall, P. C., & Wilcox, L. E. (1979). Self-control in children: Development of a rating scale. *Journal of Consulting and Clinical Psychology*, 47, 1020–1029.(*)
- Kendall, P. C., & Wilcox, L. E. (1980). Cognitive-behavioral treatment for impulsivity: Concrete versus conceptual training in non-self-controlled problem children. *Journal of Consulting and Clinical Psychology*, 48(1), 80–91.(*)
- Kendall, P. C., & Zupan, B. A. (1981). Individual versus group application of cognitive-behavioral self-control procedures with children. *Behavior Therapy*, 12, 344–359.(*)
- Kendall, P. C., Zupan, B. A., & Braswell, L. (1981). Self-control in children: Further analyses of the Self-Control Rating Scale. *Behavior Therapy*, 12, 667–681.
- Reynolds, W. M., & Stark, K. D. (1986). Self-control in children: A multi-method examination of treatment outcome measures. *Journal of Abnormal Child Psychology*, 14(1), 13–23.(*)
- Zelko, F. A. (1991). Comparison of parent-completed behavior rating scales: Differentiating boys with ADD from psychiatric and normal controls. *Journal of Developmental and Behavioral Pediatrics*, 12(1), 31–37.(*)

Impulsivity/Low Self-Control:

Measure 18

Ages: late elementary and middle
school grades

Title:

Teacher's Self-Control Rating Scale

Scale: Entire instrument

Author:

Laura Lynn Humphrey

How To Obtain	Contact Laura Lynn Humphrey, Ph.D., The Family Institute, 618 Library Place, Evanston, IL 60201. Phone: (847) 733-4300.
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Cost	Availability and price information can be obtained from the author.
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Ages	The instrument is appropriate for late elementary and middle school children.
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Content	The Teacher's Self-Control Rating Scale is a shortened version of the Self-Control Rating Scale (Kendall & Wilcox, 1979). It contains 15 items that measure two factors of self-control: cognitive/personal and behavioral/interpersonal. The cognitive/personal factor measures planfulness and ability to complete tasks; examples of items are "Fails to complete assignments when the adult is not watching," "Plans ahead what to do before acting," and "Is distracted from work or responsibilities." Examples of items from the behavioral/interpersonal scale are "Gets into arguments and/or fights with other children," "Disrupts others when they are doing things," and "Has to have things right away." Scores for these two subscales can be obtained, or a total score may be used.
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Time and Special Arrangements	Administration instructions are not given in the source document.
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Evidence of Reliability	Alphas of .93 and .94, a 22-week retest correlation of .94, and an interteacher correlation of .80 have been reported.
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Evidence of Criterion-Related Validity	A correlation between the total scores of a teacher rating of aggression is .81. The scale also distinguished a group of children with behavior problems from other children with moderate efficiency ($r = .45$).
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Evidence of Appropriateness for Different Groups	No evidence of appropriateness for diverse groups was found; the instrument was developed using a large sample of mostly White, suburban, middle-class students.
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- References**
- Humphrey, L. L. (1982). Children's and teachers' perspectives on children's self-control: The development of two rating scales. *Journal of Consulting and Clinical Psychology, 50*(5), 624–633.(*)
- Kendall, P. C., & Wilcox, L. E. (1979). Self-control in children: Development of a Rating Scale. *Journal of Consulting and Clinical Psychology, 47*, 1020–1029.
- Reynolds, W. M., & Stark, K. D. (1986). Self-control in children: A multi-method examination of treatment outcome measures. *Journal of Abnormal Child Psychology, 14*(1), 13–23.(*)

Belief in Conventional Social Rules:

Measure 19

Title:

What About You (WAY), Forms C and E

Ages: 9–10 (Form E)
11–18 (Form C)

Scale: Belief in Rules

Authors:

Gary D. Gottfredson and Denise C. Gottfredson

How To Obtain

Contact Gary D. Gottfredson, Ph.D., Gottfredson Associates, Inc., 3239B Corporate Court, Ellicott City, MD 21041. Phone: (410) 461-5530.

Cost Permission must be obtained to use the WAY questionnaire. Assessment booklets, which are reusable for Form C, cost \$.85 to \$1.00 apiece, depending on the quantity. Answer sheets cost \$.08 or \$.09 each. Scoring costs vary by form and quantity. Form C answer sheets are scanned and scored for \$.25 each. Form E booklets are keyboarded and scored for \$1.45 each.

Ages Form C is appropriate for grades 6–12 and Form E for grades 4 and 5.

Content WAY is a self-report questionnaire. It contains measures of substance abuse, demographics, and several domains of risk and protection: community, family, school, peer, and individual. Two versions are available: a 184-item Form C and a 114-item Form E. The Belief in Rules scale measures the respondent's attitude toward conventional rules, norms, and laws. Items include "Sometimes you have to be a bully to get respect," "How wrong is it to cheat on school tests?" and "If your friends got into trouble with the police, would you lie to protect them?" Form C's Belief in Rules scale contains 17 items, and Form E's Belief in Rules scale contains 13 items.

Time and Special Arrangements Administration instructions are provided, along with survey booklets and optically scannable answer sheets. A scoring service is available. The survey can be completed in a 50-minute class period in most populations.

Evidence of Reliability For Form C, alphas range from .77 to .82, and 1-year retest correlations range from .48 to .52. For Form E, alphas range from .81 to .82. A retest correlation of .3 was reported.

Evidence of Criterion-Related Validity For Form C, correlations with substance abuse range from $-.22$ to $-.48$, with a median of $-.34$. Correlations with school records (absences, disciplinary referrals, and suspensions) and a teacher rating of problem behavior range from $-.03$ to $-.31$, with a median of $-.12$. One-year predictive correlations with school records and the teacher rating of problem behavior range from .00

to $-.29$, with a median of $-.14$. For Form E, correlations with substance abuse range from $-.22$ to $-.38$, with a median of $-.30$.

Evidence of Appropriateness for Different Groups

Reliability and validity evidence was reported separately by ethnicity (African American/European American) and sex for Form C and by sex for Form E. Alpha coefficients were similar across different race (Form C) and sex (Forms C and E) groups. Correlations between the Form C Belief in Rules scale and a measure of rebellious behavior were similar for all groups, but correlations with measures of substance abuse were slightly higher for European Americans. A subsequent study (Gottfredson & Koper, 1997) of group differences in the prediction of later substance abuse showed that the Belief in Rules scale was equally predictive of variety measures of substance abuse for African-American males and females. For frequency measures of substance abuse, the Belief in Rules scale predicted better for European-American females than for other groups. The Form E scale had similar correlations with measures of substance abuse for boys and girls.

References

- Gottfredson, G. D., & Gottfredson, D. C. (1992). *Development and applications of theoretical measures for evaluating drug and delinquency prevention programs*. Paper presented at the annual meeting of the American Society of Criminology, New Orleans.(*)
- Gottfredson, G. D., & Gottfredson, D. C. (1992). *What About You Forms C and E, research editions: Supplementary information*. Ellicott City, MD: Gottfredson Associates, Inc.(*)
- Gottfredson, G. D., & Koper, C. S. (1997). Race and sex differences in the measurement of risk for drug use. *Journal of Quantitative Criminology*, 13, 325–347.

Belief in Conventional Social Rules:

Measure 20

Title:

Research Triangle Institute (RTI) Panel Study Survey

Author:

Research Triangle Institute

Ages: high school grades

Scale: Attitudinal Tolerance of
Deviance

How To Obtain	Contact National Technical Information Service, 5285 Port Royal Rd., Springfield, VA 22161. Phone: (703) 605-6000, Fax: (703) 321-4650.
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Cost	\$81.50
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Ages	This survey is appropriate for use with adolescents of high school age.
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Content	The RTI Panel Study Survey is a self-report questionnaire. Attitudinal Tolerance of Deviance contains 12 items that measure the respondent's opinion about how wrong it is to commit different delinquent acts. There are four response choices ranging from "not wrong" to "very wrong." Examples of items are "How wrong is it to break into a place that is locked just to look around?" "How wrong is it to beat up another kid without much reason?" and "How wrong is it to skip school without a legitimate excuse?"
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Time and Special Arrangements	Administration instructions were not given in the source documents.
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Evidence of Reliability	Alpha coefficients for the Attitudinal Tolerance of Deviance scale reported in Jessor, Donovan, and Widmer, (1980) ranged from .84 to .88. Four-year retest coefficients of .40 for males and .36 for females were reported.
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Evidence of Criterion-Related Validity	Correlations with substance abuse range from $-.27$ to $-.43$, with a median of $-.36$; correlations with self-reported problem behavior range from $-.51$ to $-.56$, with a median of $-.53$. Four-year predictive correlations range from $-.10$ to $-.29$ (median = $-.22$) with substance abuse and from $-.17$ to $-.32$ (median = $-.24$) with problem behavior.
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Evidence of Appropriateness for Different Groups	The sample used in the source documents (Panel Study) was 48 percent male. The ethnic composition was 22 percent Latino, 16 percent African American, 19 percent Native American, and 43 percent other. Psychometric information was not reported separately by ethnic subgroup.
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- References** Jessor, R., Donovan, J. E., & Widmer, K. (1980). *Adolescent drinking behavior, Volume II: Psychosocial factors in adolescent alcohol and drug use: The 1978 National Sample Study and the 1974–78 Panel Study*. Research Triangle Park, NC: Research Triangle Institute.(*)
- Rachal, J. V., Williams, J. R., Brehm, M. L., Cavanaugh, B., Moore, R. P., & Eckerman, W. C. (1975). *A national study of adolescent drinking behavior, attitudes, and correlates*. Research Triangle Park, NC: Research Triangle Institute. (NTIS No. PB 246 002)

Belief in Conventional Social Rules:

Measure 21

Ages: 11–18

Title:

Communities That Care Youth Survey

Scales: Attitudes Favorable
Toward Antisocial
Belief Behavior

Authors:

Michael Arthur, John A. Pollard, J. David Hawkins, and
Richard F. Catalano

How To Obtain	Contact Customer Service, Developmental Research and Programs, Inc., 130 Nickerson St., #107, Seattle, WA 98119. Phone: (206) 286-1805, Fax: (206) 286-1462.
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Cost	Cost is \$1.80 per survey form. There are additional costs (\$300–\$625) for analysis and report generation. For an additional fee, the survey can be customized to better meet individual users' needs.
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Ages	The survey is intended for ages 11 through 18 (grades 6–12).
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Content	The Communities That Care Youth Survey contains 201 items. It includes scales measuring substance abuse; demographic characteristics; and community, family, school, peer, and individual factors related to substance abuse. The Attitudes Favorable Toward Antisocial Behavior (AFAB) scale and Belief scale are each composed of four items that ask respondents how wrong it is for someone their age to take a handgun to school (AFAB), for example, and whether they think it is okay to engage in such delinquent activities as cheating at school. Responses are on a four-point scale.
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Time and Special Arrangements	The survey instrument is designed to be administered in a single class period of 45 minutes to 1 hour. Administration instructions are provided by Developmental Research and Programs, Inc. (DRP). The survey is provided on an optically scannable form. Completed surveys are returned to DRP for scoring, development of the data base, analysis, and report generation. The survey organizer is responsible for administration and return of the completed surveys to DRP.
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Evidence of Reliability	The authors reported an alpha of .80 for AFAB and .73 for Belief.
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Evidence of Criterion-Related Validity	Correlations between the AFAB scale and substance abuse range from .29 to .35, with a median of .34. The scale correlated .49 with antisocial behaviors. The correlations between the Belief scale and substance abuse range from
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–.34 to –.40, with a median of –.37. The Belief scale correlated –.34 with anti-social behaviors.

**Evidence of
Appropriateness for
Different Groups**

The data presented above were from a majority White adolescent population. Survey appropriateness has not been assessed for specific minority populations.

References

A manual or other source document is not available for this newly developed instrument. Contact John Pollard with questions at (206) 286-1805.

Attitudes Favoring Substance Abuse:

Measure 22

Title:

Drug Attitudes Scale (DAS)

Ages: high school grades

Scale: Drug Attitude

Authors:

Michael S. Goodstadt, Gaynoll Cook, Simmie Magid, and Valerie Gruson

How To Obtain	Contact Michael Stephen Goodstadt, Addiction Research Foundation, 33 Russell Street, Toronto, Ontario M5S 2S1, Canada. (Note: Questions are included in Goodstadt et al., 1978.)
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Cost	The instrument is in the public domain. Users must reproduce and score the instrument.
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Ages	DAS is appropriate for use with high school students.
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Content	The DAS contains 60 items that are divided into the Tranquilizer, Barbiturate, Heroin, Opiate, Speed, Alcohol, Cannabis, Hallucinogen, Tobacco, General Drug Use, and Amphetamine subscales. Each subscale contains six items that measure attitudes toward the specific substance or class of substances. Examples of items from various subscales are "A person should never take heroin for any reason," "There is nothing wrong with drinking alcohol," "The risks involved in opiate use are not worth taking," and "People who use drugs are a burden to society."
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Time and Special Arrangements	Administration instructions are not given in the source document but can be obtained from the author.
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Evidence of Reliability	Alphas range from .87 to .97 for specific subscales.
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Evidence of Criterion-Related Validity	The median correlation of the attitudes scales was .39 with prior substance abuse and .48 with intentions to use.
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Evidence of Appropriateness for Different Groups	DAS was developed using data from a randomly selected sample of high school students in Ontario, Canada. Specific demographic information for the sample was not provided.
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References	Goodstadt, M. S., Cook, G., Magid, S., & Gruson, V. (1978). The Drug Attitudes Scale (DAS): Its development and evaluation. <i>International Journal of the Addictions</i> , 13(8), 1307-1317.(*)
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Attitudes Favoring Substance Abuse:
Measure 23

Title:

Survey of Youth

Author:

Ronald L. Akers

Ages: 12–18

Scale: Definitions Favorable/
Unfavorable to Use

How To Obtain	Contact Ronald L. Akers, University of Florida, Department of Sociology, P.O. Box 115950, Gainesville, FL 32611-5950. Phone: (352) 392-1025, E-mail: rla@soc.ufl.edu
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Cost	Users must compose, reproduce, and score the scale.
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Ages	This survey was used to collect data from adolescents aged 12 to 18.
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Content	The Survey of Youth is a self-report questionnaire based on a social learning theory of substance abuse. Definitions Favorable/Unfavorable to Use is composed of three subscales: Techniques of Neutralization, Law-Abiding or Law-Violating Definitions, and Positive or Negative Definitions of Use. The Techniques of Neutralization subscale contains three items concerning alcohol and three items concerning other substance abuse. An example of an item in this scale is “Teenagers who use drugs really shouldn’t be held responsible since they are under too much pressure to resist.” The Law-Abiding or Law-Violating scale measures attitudes toward law in general and substance laws specifically, for example, “The fact that it is against the law makes the use of drugs wrong.” Positive or Negative Definitions of Use is a four-item scale that asks if the respondent approves or disapproves of the use of alcohol, marijuana, stimulants, and stronger substances.
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Time and Special Arrangements	The scales are brief.
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Evidence of Reliability	No information about reliability was given in the source document (Akers, Krohn, Lanza-Kaduce, & Radosevich, 1979).
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Evidence of Criterion-Related Validity	Techniques of Neutralization correlated .34 with alcohol use and .48 with marijuana use. Law-Abiding/Law-Violating Definitions correlated .47 with use of alcohol and .40 with use of marijuana, and Positive or Negative Definitions of Use correlated .52 with alcohol use and .72 with marijuana use.
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**Evidence of
Appropriateness for
Different Groups**

The survey has been used on a large sample of male and female students from Midwestern States.

References

Akers, R. L., Krohn, M. D., Lanza-Kaduce, L., & Radosevich, M. (1979).
Social learning and deviant behavior: A specific test of a general theory.
American Sociological Review, 44, 636–655.(*)

Attitudes Favoring Substance Abuse:

Measure 24

Title:

What About You (WAY), Forms C and E

Ages: 9–10 (Form E)
11–18 (Form C)

Scales: Attitudes Favoring Drug
Use (Form C)
Intentions to Abstain
(Form E)

Authors:

Gary D. Gottfredson and Denise C. Gottfredson

How To Obtain	Contact Gary D. Gottfredson, Ph.D., Gottfredson Associates, Inc., 3239B Corporate Court, Ellicott City, MD 21041. Phone: (410) 461-5530.
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Cost	Permission must be obtained to use the WAY questionnaire. Assessment booklets, which are reusable for Form C, cost \$.85 to \$1.00 apiece, depending on the quantity ordered. Answer sheets cost \$.08 or \$.09 each. Scoring costs vary depending on the form and the quantity. Form C answer sheets are scanned and scored for \$.25 each. Form E booklets are keyboarded and scored for \$1.45 each.
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Ages	Form C is meant for use with children in grades 6–12, and Form E is for grades 4 and 5.
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Content	WAY is a self-report questionnaire. It contains measures of substance abuse, demographics, and several domains of risk and protection: community, family, school, peer, and individual. Two versions are available: a 184-item Form C and a 114-item Form E. The Attitudes Favoring Drug Use scale contains 10 items that measure the respondent's opinion of how wrong it is to use or sell substances and intentions to use drugs or alcohol in the future. Examples of items are "I will never try marijuana or other drugs" and "How wrong is it for you or someone your age to use alcohol?" Intentions to Abstain contains three items measuring plans to use or refrain from substance abuse in the future. An example of an item from this scale is "I will never smoke cigarettes."
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Time and Special Arrangements	Administration instructions are provided, along with survey booklets and optically scannable answer sheets. A scoring service is available. The survey can be completed in a 50-minute classroom period for most populations.
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Evidence of Reliability	For the Form C Attitudes Favoring Drug Use scale, alphas range from .72 to .85, and 1-year retest correlations range from .42 to .66. For the Form E scale, alphas range from .48 to .53, and a retest correlation of .63 has been reported.
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**Evidence of
Criterion-Related
Validity**

Correlations between the Form C Attitudes Favoring Drug Use scale and substance abuse range from .34 to .72, with a median of .49. Concurrent correlations with school records (absences, disciplinary referrals, and suspensions) and a teacher rating of problem behavior range from .00 to .29, with a median of .10; 1-year predictive correlations with the same criteria range from .02 to .34, with a median of .14. Correlations between the Form E scale and substance abuse range from $-.17$ to $-.67$, with a median of $-.55$.

**Evidence of
Appropriateness for
Different Groups**

Reliability and validity information for Form C was reported separately by sex and ethnicity (African American and European American) and for Form E by sex. Reliability appears similar across groups. Correlations with measures of substance abuse tended to be higher for European-American students. Another study shows that Attitudes Favoring Drug Use predicts the variety of substances used in the following year equally well for members of the four subgroups but predicts frequency of use less well for African-American females than for the other three groups (Gottfredson & Koper, 1996). For Form E, correlations with measures of substance abuse were somewhat stronger for girls.

References

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Social Competency Skills and Peer Rejection:
Measure 25

Title:
Peer Rejection

Authors:
J. D. Coie, A. F. Newcomb, W. M. Bukowski, S. R. Asher, and
K. A. Dodge

Ages: 4–12

Scale: Rejected Status

How To Obtain	Each form must be created locally using the procedures summarized below.
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Cost Costs include the time and materials necessary to create the forms and score the nominations.

Ages Peer rejection status can be measured by using the methods described below for children as young as preschool age (4 years, using pictures of peers rather than written names) and as old as middle-school age (12 years).

Content Several different methods have been developed for assessing peer rejection status. Each method uses, as a primary source of data, classmates’ reports of their liking for the target student. The most commonly used method, developed by Coie, Dodge, and Coppotelli, (1982), presents a roster of all children in a grade level in a single school to each child and asks the children to nominate the students they like most (“LM”) and the three they like least (“LL”). The absolute frequency of LL and LM nominations is computed for each child. These scores are standardized within a grade. Social preference (“SP”) is calculated by subtracting the standardized LL from the standardized LM (LM – LL). This SP score is then restandardized within each grade. Coie et al. (1982) identified rejected children as those who have a final SP score below –1.0, a standardized LL greater than 0, and a standardized LM less than zero (or in some studies, an absolute frequency of positive nominations of 0 in place of the last two conditions). Newcomb and Bukowski (1983) developed a related method.

Asher and Dodge (1986) present a different method. Children are given a roster of all children in the class and asked to nominate the three they like most. Instead of asking children to nominate the three they like the least, they are asked to indicate how much they like to play with each peer by circling a number on a scale from 1 (“I don’t like to”) to 5 (“I like to a lot”). A “lowest playing rating” (“LPR”) score, the absolute frequency of rating of 1 received from peers, is computed for each child and is standardized within the classroom. The absolute frequency of LM nominations is computed for each child as described above, and this score is standardized within the grade. Social preference (“SP”) is calculated by subtracting the standardized LPR from the stan-

dardized LM ($LM - LPR$). This SP score is then restandardized within each grade. Rejected children are those who have a final SP score below -1.0 and an absolute frequency of positive nominations of 0.

A variant of the Asher and Dodge (1986) method uses the average of all of the ratings received by peers. "Rejected" status can be defined by using this method as an average rating, which is one-half or one full standard deviation below the average rating for the sample.

Time and Special Arrangements

The methods are relatively cumbersome because they require complete rosters of classmates and therefore must be tailor-made for each setting. The scoring of the nominations is also complex, requiring considerable technical expertise.

Evidence of Reliability

Corrected split-half correlations for the Coie et al. (1982) index range from .45 to .82. Retest correlations range from .29 to .57 for a 1-year interval, from .33 to .50 for a 2-year interval, and from .29 to .48 for a 3-year interval. One-year retest kappas for the Asher and Dodge index range from .39 to .53. Retest kappas were .57 for a 5-month interval and .53 for a 2-year interval. Two-week retest kappas for the Asher and Dodge variant range from .54 to .60, and 1-year retest kappas range from .29 to .30.

Evidence of Criterion-Related Validity

The Coie et al. index correlated .72 with teacher-rated aggression and .52 with peer-rated aggression. Effect sizes (r) were .29 for teacher-rated aggression and .04 for self-rated problem behavior. Effect sizes range from .09 to .27 (median = .18) for teacher-rated problem behavior; from .04 to .43 (median = .29) for parent, observer, and peer ratings of aggression; and from .27 to .32 (median = .30) for parent and peer ratings of problem behavior. Rejected status from the Asher and Dodge index was correlated .28 with peer-rated aggression, .18 with legal offenses, .19 with substance dependence, .20 with self-reported problem behavior, .58 and .41 with teacher-rated problem behavior, and .44 and .33 with parent-rated problem behavior. Correlations for the Asher and Dodge variant range from .22 to .33 with teacher-rated aggression, and from .43 to .57 for peer-rated aggression.

Evidence of Appropriateness for Different Groups

The peer nomination procedures described above have been used in many studies with diverse populations. In a study of preschoolers, approximately half of whom were minority group members, Howes (1988) found that peer rejection measured using a variant of one of the procedures above for non-readers was related as expected to teachers' ratings of difficulty with peers and to observers' ratings of difficulty interacting with peers. In a study of African-American males in grades 1 and 3, Dodge, Coie, Pettit, and Price, (1990) demonstrated that peer nominations obtained using a slight modification of the Coie et al. (1982) procedure in a classroom setting corresponded with ratings obtained in a play group setting. Peer rejection was clearly related to aggressive behavior in this sample of African-American boys. An early study by Sells and Roff (1967) employed large samples of African-American and White boys and girls and found no substantial differences by race or gender in the reliability of the peer nominations, using a split-half procedure. The

methods have also been shown to be valid when used with French Canadian (Boivin, Dorval, & Begin, 1990) and German (Mayr, 1992) samples.

References

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Social Competency Skills and Peer Rejection:

Measure 26

Title:

Social Skills Rating System (SSRS)

Authors:

Frank M. Gresham and Stephen N. Elliott

Ages: preschool–secondary
school (parent and
teacher forms)
grades 3–12 (student
forms)

Scale: Total Social Skills

How To Obtain

Contact American Guidance Service, Publishers' Building, Circle Pines, MN 55014. Phone: (800) 328-2560.

Cost SSRS materials can be purchased from the publisher. Questionnaire packages (25 per package) cost \$13.50 to \$15.00, depending on the quantity. A manual costs \$25. Scoring software is also available at a cost of \$104, including manual.

Ages Separate parent and teacher forms can be used with preschool (ages 3–5), elementary school (grades K–6), and secondary school (grades 7–12) populations. The parent forms contain 38–40 items; the teacher forms contain 40–48 items. The student form is available for two age levels: elementary (grades 3–6, 34 items) and secondary (grades 7–12, 39 items).

Content SSRS is a multirater approach to assessing social competency skills from the viewpoint of teachers, parents, and students. The three forms are self-administered questionnaires, each containing 30 to 40 items measuring social competency skills and asking the respondent to report (on a three-point scale) how often the target child exhibits the skills. SSRS includes problem behavior and academic competency scales as well, but only the social skills items are discussed in this section. The "Total Scale" of the Social Skills section of the assessment includes items measuring a variety of social competency skills identified in earlier research as related to problem behaviors. Sample items are "Starts conversations," "Waits turn in games," "Listens to friends' problems," and "Ignores children's teasing." The manual provides instructions for subdividing the items to form subscales of specific social skills, but the subscales are highly redundant. The use of the Total Social Skills scale is recommended.

Time and Special Arrangements

Teacher ratings should be conducted after the teacher has observed the student for at least 2 months. Each full SSRS takes 15–25 minutes to complete. The social skills section, using the frequency responses only, would be expected to take no more than 15 minutes to complete. Hand-scoring takes approximately 5 minutes per booklet.

Evidence of Reliability

The manual reports the results of a validation study for the elementary and secondary forms using a large national sample of children, parents, and teach-

ers. The preschool forms were studied using a 10-State sample involving approximately 200 preschool students. Alphas ranged from .87 to .90 for the Parent forms, from .93 to .96 for the Teacher forms, and from .80 to .87 for the Student forms. A subset of the national sample of elementary school students rated the same children twice, 4 weeks apart. Retest reliability coefficients for the Total Social Skills scale of the Elementary forms were .85 for the Teacher form, .87 for the Parent form, and .68 for the Student form. The Elementary Teacher form had retest correlations of .90 for a 6-week interval and .87 for an unreported interval. Interrater reliability was assessed by correlating scores of different raters of the same child. For all levels, teacher-parent agreement on student ratings was low to moderate (ranging from .25 to .36). Teacher-student agreement was also low to moderate (.22 for elementary and .41 for secondary), and parent-student agreement was low (.12 for elementary and .36 for secondary), but statistically significant.

**Evidence of
Criterion-Related
Validity**

Correlations between the Parent form and parent ratings of problem behavior range from $-.37$ to $-.55$, with a median of $-.43$. Correlation between the Teacher forms and teacher ratings of problem behavior range from $-.57$ to $-.91$, with a median of $-.59$. A correlation between the Student form and a self-report of problem behavior was $-.45$.

**Evidence of
Appropriateness for
Different Groups**

The sample in a 10-State study of the SSRS was composed of equal numbers of males and females, and included both African-American (18 percent) and Hispanic (6 percent) students. Reliabilities were about equal for males and females but were not reported separately for ethnic or race subsamples. Powell and Elliott (1993) studied Native Americans and European Americans and found evidence of validity for both samples, although the evidence was somewhat stronger for Native Americans. Other studies (Elliott, Barnard, & Gresham, 1989; Gresham, Elliott, & Black, 1987) have used the SSRS with ethnically diverse samples but have not specifically examined the reliability and validity separately for the different populations.

References:

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Social Competency Skills and Peer Rejection:
Measure 27

Title:

Walker-McConnell Scale of Social Competence and School Adjustment—Elementary Version (K–6)

Ages: 6–12

Scales: Teacher-Preferred Social Behavior
Peer-Preferred Social Behavior

Authors:

Hill M. Walker and Scott R. McConnell

How To Obtain	Contact Singular Publishing Company, 4284 41st Street, San Diego, CA 92105. Phone: (800) 521-8545.
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Cost	A technical manual and set of 20 forms are available for \$54.95. Additional forms are available in sets of 20 for \$19.95.
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Ages	Teachers rate students aged 6–12 years (K–6th grade).
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Content	The Walker-McConnell Scale was designed to sample the domains of adaptive classroom behavior and interpersonal social competence. The entire instrument consists of 43 items to be completed by teachers. Ten of these items measure School Adjustment Behavior, which is not included in the definition of social competency. The remaining 33 items are divided between two scales measuring social competency. These scales are intended to assess skills necessary to maintain competent social interactions and relations with others. The Teacher-Preferred Social Behavior scale taps behaviors necessary to make satisfactory adjustments in situations controlled by the teacher. It consists of 16 items such as “Shows sympathy for others” and “Cooperates with peers in group activities or situations.” The Peer-Preferred Social Behavior scale taps behaviors necessary to make satisfactory adjustments in situations dominated by peer interaction. It contains 17 items such as “Plays games and activities at recess skillfully” and “Compromises when the situation calls for it.”
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Time and Special Arrangements	Teachers rate students’ competencies after a minimum of 2 months of exposure to the child. Instructions are included on the instrument, and it takes 5–10 minutes to rate each child using the entire 43-item instrument. The technical manual includes instructions for hand-scoring and translating scores into standard scores based on the national norm sample.
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Evidence of Reliability	The developers reported an alpha of .97 for the Teacher-Preferred Social Behavior scale. Other evidence shows that interrater correlations have ranged
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from .11 to .73, with a median of .49. Retest correlations ranged from .85 to .90 for 2- to 3-week intervals and from .48 to .69 for 8-month to 2-year intervals. Retest correlations for Peer-Preferred Social Behavior range from .80 to .94 for short (2- to 4-week) intervals using the same raters and (.22 to .72, with a median of .48) for periods ranging from 8 months to 3 years, some using different raters at the different time points. Alpha was .95 in a national norm sample of 1,812 students. Interrater reliabilities ranged from .62 to .74, with a median of .64.

**Evidence of
Criterion-Related
Validity**

Correlations between the Teacher-Preferred Social Behavior scale and teacher-rated problem behavior ranged from $-.41$ to $-.65$. The correlations between the Peer-Preferred Social Behavior scale and teacher-rated problem behavior ranged from $-.22$ to $-.44$; predictive correlations of the scale with teacher ratings of problem behavior ranged from $-.21$ to $-.24$ for 1-, 2-, 3-, and 4-year intervals. Effect sizes for classification in problem behavior group ranged from $-.54$ to $-.73$ for Teacher-Preferred Behavior and from $-.31$ to $-.87$ for Peer-Preferred Behavior.

**Evidence of
Appropriateness for
Different Groups**

The appropriateness for ethnically diverse samples remains to be established for the Walker-McConnell scales. All studies located so far have involved predominantly White samples, although many have involved females in equal proportion to males.

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Social Competency Skills and Peer Rejection:
Measure 28

Title:

Walker-McConnell Scale of Social Competence and School Adjustment—Adolescent Version

Ages: 13–18

Scales: Self-Control
Peer Relations
Empathy

Authors:

Hill M. Walker and Scott R. McConnell

How To Obtain	Contact Singular Publishing Company, 4284 41st Street, San Diego, CA 92105. Phone: (800) 521-8545.
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Cost	A technical manual and set of 20 forms are available for \$54.95. Additional forms are available in sets of 20 for \$19.95.
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Ages	Teachers rate students in grades 7–12, or ages 13–18.
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Content	The adolescent version of the Walker-McConnell Scale is an upward extension of the original Walker-McConnell Scale described below. Like the original scale, it was designed to sample the domains of adaptive classroom behavior and interpersonal social competence. The entire scale consists of 53 items, which are completed by teachers. Fifteen of these items measure School Adjustment Behavior, which is not included in the construct of social competency as defined here. The remaining 38 items are divided among three scales measuring social competency. These scales are intended to assess skills necessary to maintain adequate social interactions and relations with others. The Self-Control scale overlaps considerably in content with the Teacher-Preferred Social Behavior scale in the elementary version and contains 13 items, such as “Controls temper” and “Displays self-control in difficult situations.” The Peer Relations scale overlaps considerably with the Peer-Preferred Social Behavior scale from the elementary version and contains 16 items, such as “Shares laughter with peers” and “Interacts with a number of different peers.” The Empathy scale also shares content with the Teacher-Preferred Social Behavior scale in the elementary version and contains six items, such as “Shows sympathy for others” and “Is sensitive to the needs of others.”
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Time and Special Arrangements	Teachers rate students’ competencies after a minimum of 2 months of exposure to the child. Instructions are included on the instrument, and it takes 5–10 minutes to rate each child for the entire 53-item instrument. The technical manual includes instructions for manual scoring and translating scores into standard scores based on the national norm sample.
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Evidence of Reliability	The adolescent version of the Walker-McConnell Scale was recently developed, and little evidence has been amassed in support of its reliability and validity. Alphas were .94 and .95 for Self-Control, .95 for Peer Relations, and .89 and .91 for Empathy. Three studies have reported retest reliabilities. Retest correlations for a 4- to 5-week interval were .33 and .85 for Self-Control, .82 and .90 for Peer Relations, and .76 and .87 for Empathy. One-year retest correlations were .61, .73, and .64 for the three subscales, respectively.
Evidence of Criterion-Related Validity	Correlations with a teacher rating of problem behavior are $-.65$ for Self-Control, $-.47$ for Peer Relations, and $-.63$ for Empathy. Effect sizes (r) for comparison of parole and probation sample with others were $-.83$, $-.45$, and $-.70$ for the three subscales, respectively. The Empathy subscale was also shown to discriminate between “highly antisocial” and “at-risk” youth (effect size $[r] = -.51$) and arrest versus no-arrest groups (effect size $[r] = -.33$).
Evidence of Appropriateness for Different Groups	All studies located so far have involved predominantly White male samples, although some have involved females in equal proportion to males.
References	<p>Merrell, K. W. (1993). Using behavior rating scales to assess social skills and antisocial behavior in school settings: Development of the School Social Behavior Scales. <i>School Psychology Review</i>, 22(1), 115–133.(*)</p> <p>Walker, H. M., & McConnell, S. R. (1993). <i>Technical manual for the Walker-McConnell Scale of Social Competence and School Adjustment: A social skills rating scale for teachers</i>. San Diego, CA: Singular Publishing Company.(*)</p> <p>Walker, H. M., Stieber, S., & Eisert, D. (1991). Teacher ratings of adolescent social skills: Psychometric characteristics and factorial replicability across age-grade ranges. <i>School Psychology Review</i>, 20(2), 301–314.(*)</p>

Substance Use in the Family:

Measure 29

Ages: 11–19

Title:

Scale: N/A

Various Items or Sets of Items Measuring Family History of Substance Abuse

Authors:

Various authors (see reference list)

How To Obtain	Items are listed in the references below.
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Cost	Users must assemble, compose, reproduce, and score measures composed of these items.
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Ages	Questions about family substance abuse can be answered by youth in early and late adolescence. Respondents as young as 11 and 12 (grade six) and as old as 18–19 have been asked about their family's substance abuse. However, for younger children—those in grade five (ages 9 and 10) and below—the parent or sibling should be asked directly using one of the self-report instruments described in the Problem Behavior section. Direct assessment of family members' substance abuse can also be used with older target respondents (e.g., Gfroerer, 1987; Needle et al., 1986), but target respondents' reports of their family members' substance abuse have been shown to be useful predictors of their own use.
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Content	Several studies have demonstrated the utility of items or sets of items as measures of family history of substance abuse. These item sets are summarized below:
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Bauman, Foshee, Linzer, and Koch (1990)—Parental cigarette smoking was measured by asking the adolescent whether each parent had ever smoked cigarettes. Parents were classified as *current smokers* if they were smokers at the time of the adolescent interview. (All other parents were classified as non-smokers.) A second variable, *lifetime smoker*, distinguished parents who had ever smoked (current and ex-smokers) from parents who had never smoked.

Chassin, Presson, Sherman, Montello, and McGrew (1986)—Parental smoking was assessed using two items: "My mother smokes cigarettes" and "My father smokes cigarettes." Respondents received a score of 0 if neither parent smoked, 1 if one parent smoked, and 2 if both parents smoked.

Lopez, Redondo, and Martin (1989)—Respondents were asked items such as, “How often does your mother [father] use tobacco [alcohol/marijuana/tranquilizers]?” Responses were “never,” “sometimes,” and “often.”

McAllister, Krosnick, and Milburn (1984)—One item asked, “Do you have any brothers and/or sisters who smoke cigarettes regularly?”

Spielberger, Jacobs, Crane, and Russell (1983)—Parental smoking was defined as (a) neither parent smoked, (b) mother or father smoked, but not both, and (c) both parents smoked. Students with older siblings were assigned to one of the following three categories: (a) neither older brother nor older sister smoked; (b) older brother or older sister smoked, but not both; (c) older brother and older sister both smoked.

Time and Special Arrangements	The item sets are brief.
Evidence of Reliability	Reliability evidence was not reported for any of the items listed above.
Evidence of Criterion-Related Validity	Target respondents' reports of parent's smoking predicted adolescents' smoking (Bauman, Foshee, Linzer, & Koch 1990; Chassin, Presson, Sherman, Montello, & McGrew, 1986; Spielberger, Jacobs, Crane, & Russell, 1983). Siblings' smoking was significantly related to target adolescents' smoking frequencies (McAllister, Krosnick, & Milburn, 1984). An adolescent's perceptions of the mother's and father's tobacco, alcohol, and tranquilizer use was significantly associated with the adolescent's substance abuse (Lopez, Redondo, & Martin, 1989). Correlations with substance abuse ranged from $-.02$ to $.46$, with a median of $.24$.
Evidence of Appropriateness for Different Groups	Lopez et al. used a sample of male secondary school students in Spain. Most studies either used predominantly White samples or did not provide information on the sample's ethnic composition. Two of the studies reviewed (Chassin et al., 1986; Spielberger et al., 1983) showed that parental cigarette smoking was significantly related to female, but not to male, respondents' smoking. These two studies do not constitute evidence of differential validity for males and females but suggest that gender should be examined in future research assessing the relationship between family's substance abuse and respondent's use.
References	<p>Aaro, L. E., Hauknes, A., & Berglund, E. L. (1981). Smoking among Norwegian school children 1975–1980. II. The influence of the social environment. <i>Scandinavian Journal of Psychology</i>, 22, 297–309.(*)</p> <p>Barry, K. L., & Fleming, M. F. (1990). Family cohesion, expressiveness and conflict in alcoholic families. <i>British Journal of Addiction</i>, 85, 81–87.(*)</p>

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Substance Use in the Family:

Measure 30

Ages: 11–18

Title:

Communities That Care Youth Survey

Scale: Family History of
Antisocial Behavior

Authors:

Michael Arthur, John A. Pollard, J. David Hawkins, and
Richard F. Catalano

How To Obtain	Contact Customer Service, Developmental Research and Programs, Inc., 130 Nickerson St., #107, Seattle, WA 98119. Phone: (206) 286-1805, Fax: (206) 286-1462.
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Cost	Cost is \$1.80 per survey form. There are additional costs (\$300–\$625) for analysis and report generation. For an additional fee, the survey can be customized to better meet individual users' needs.
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Ages	The survey instrument has been used with respondents aged 11 through 18 (grades 6–12).
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Content	The Communities That Care Youth Survey contains 201 items. It includes scales measuring substance abuse; demographic characteristics; and community, family, school, peer, and individual factors related to substance abuse. The Family History of Antisocial Behavior scale is composed of six questions such as "Has anyone in your family ever had a severe alcohol or drug problem?" and "Has any of your brothers and sisters ever smoked marijuana?" Yes/no response categories are used for the sibling questions. Two of the six items do not measure family substance abuse, but instead measure sibling antisocial behavior.
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Time and Special Arrangements	The survey instrument is designed to be administered in a single class period of 45 minutes to 1 hour. Administration instructions are provided by Developmental Research and Programs, Inc. (DRP). The survey is provided on an optically scannable form. Completed surveys are returned to DRP for scoring, development of the data base, analysis, and report generation. The survey organizer is responsible for administration and return of the completed surveys to DRP.
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Evidence of Reliability	The authors reported an alpha of .73 for Family History of Antisocial Behavior scale.
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**Evidence of
Criterion-Related
Validity**

The Family History of Antisocial Behavior scale had correlations ranging from .30 to .43 with lifetime use and from .20 to .34 with use of cigarettes, alcohol, marijuana, and illicit substances in the past month.

**Evidence of
Appropriateness for
Different Groups**

The data presented above were obtained on a sample consisting mostly of White adolescents. Detailed analysis of survey appropriateness was not attempted for specific ethnic and racial populations.

References

This is a recently developed instrument. A manual is not available. Contact John Pollard with questions at (206) 286-1805.

Parental Attitudes Favorable to Substance Abuse:

Measure 31

Ages: 11–20

Scale: N/A

Title:

Various Items or Scales Measuring Parental Attitudes Favorable To Substance Abuse

Authors:

Various authors (see reference list below)

How To Obtain

Items are listed in the source documents. However, permission to use items from the Andrews et al. study should be obtained from Judy Andrews (address below).

Cost

For information on the use and cost of the items used in the Andrews et al. study, contact Judy A. Andrews, Oregon Research Institute, 1715 Franklin Blvd., Eugene, OR 97403. Phone: (503) 484-2123. The items from the Barnes and Welte, McDermott, or McCarthy et al. must be composed, duplicated, and scored by the user.

Ages

The items and scales listed above have been used with youths between the ages of 11 and 20.

Content

Studies have used individual items or sets of items to directly assess parental attitudes about their children's substance abuse or to assess these attitudes indirectly by asking the child to report their perceptions of their parents' attitudes. The content of these item sets is summarized below.

Andrews, Hops, Ary, Tildesley, and Harris (1993)—Both parents report on their attitudes toward alcohol, cigarettes, and marijuana; adolescents report on their perceptions about their parents' attitudes. The respondents answered questions using a five-point Likert response format (from “strongly agree” to “strongly disagree”). Parents respond to “I believe that smoking cigarettes will hurt an adolescent's health.” This question is also asked with reference to alcohol and marijuana use. Parallel questions are administered to the adolescent using each parent as the referent.

Barnes and Welte (1986)—Respondents were asked what their parents' attitudes were regarding people their age drinking beer. Respondents chose one of the following answers: “strongly disapprove,” “mildly disapprove,” “neither approve or disapprove,” “mildly approve,” or “strongly approve.”

McCarthy, Newcomb, Maddahian, and Skager (1986)—Perceived parental attitudes toward substance abuse were assessed by two items rated on a five-point scale from “strongly against” to “strongly in favor of.” The two items are: “My parents are _____ my using marijuana,” and “My parents are _____ my using alcohol (beer, wine, etc.).”

McDermott (1984)—Adolescents were asked to report their perceptions of their parents’ attitudes. The questions were “Are you allowed to use any substances at home?” “Do your parents consider some drugs all right for you to use and not others?” and “How do your parents feel about your using drugs (alcohol, tobacco, marijuana, etc.)?” If respondents answered that some substance was acceptable or the parents did not attempt to exercise control, parental attitude was classified as permissive. Parental attitude was classified as nonpermissive if no substance was acceptable. If respondents reported disagreement between the parents, parental attitude was classified as permissive because the message to their children would be unclear.

Time and Special Arrangements	The item sets are brief.
Evidence of Reliability	Andrews et al. (1993) reported alphas for their scales ranging from .77 to .95. No reliability evidence was reported for the items used in Barnes and Welte (1986), or McCarthy et al. (1986), or McDermott (1984).
Evidence of Criterion-Related Validity	Parents’ as well as adolescents’ reports of parental attitudes toward substances predicted cigarette, alcohol, and marijuana use in the Andrews et al. study. Youths’ reports of their parents’ attitudes predicted use of tobacco (McCarthy et al.), alcohol (Barnes and Welte), and drugs (McDermott) among adolescents. Correlations with substance use ranged from .01 to .55, with a median of .26.
Evidence of Appropriateness for Different Groups	Although none of the studies listed above provide reliability or validity evidence for separate ethnic subgroups, the single-item indicators found in Barnes and Welte, McCarthy et al., and McDermott have been used with White, African-American, West Indian Black, Hispanic, Asian, and Native American youth. The majority of respondents in the Andrews et al. (1993) study were predominantly White, but this study provided reliability and validity evidence for both mothers and fathers.
References	<p>Andrews, J. A., Hops, H., Ary, D., Tildesley, E., & Harris, J. (1993). Parental influence on early adolescent substance use: Specific and nonspecific effects. <i>Journal of Early Adolescence</i>, 13(3), 285–310.(*)</p> <p>Ary, D. V., Tildesley, E., Hops, H., & Andrews, J. (1993). The influence of parent, sibling, and peer modeling and attitudes on adolescent use of alcohol. <i>International Journal of the Addictions</i>, 28(9), 853–880.(*)</p>

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Family Processes:

Measure 32

Ages: 11 and older

Title:

Scale: Conflict

**Family Environment Scale (FES),
Form R**

Authors:

Rudolph H. Moos and Bernice S. Moos

How To Obtain	Contact Consulting Psychologists Press, Inc., 3803 E. Bayshore Rd., Palo Alto, CA 94303. Phone: (800) 624-1765.
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Cost	Manual costs \$44.00; Form R, \$25.25 (25 forms); answer sheets, \$12.50 (25 sheets); and scoring key, \$12.00.
Ages	The FES is intended for adults and children 11 years of age and older.
Content	The FES is a 90-item, true-false self-report questionnaire that assesses the social environment characteristics of families. The Conflict scale contains nine items, such as “We fight a lot in our family” and “Family members sometimes get so angry they throw things.”
Time and Special Arrangements	The scale scores can be based on reports from all family members and averaged together. Many studies have used FES scores based on the perceptions of only one family member, however. The entire instrument takes 15–20 minutes to complete. One scale should take 5 minutes or less time to complete.
Evidence of Reliability	Data collected by the authors yielded an alpha of .75 for individuals; 4-month and 12-month retest reliabilities for families of .66, and .71; and 3- to 10-year stabilities varying from .47 to .57 (Moos & Moos, 1994). Studies have yielded alphas ranging from .69 to .85, a retest reliability of .76 for 12 months, and an interrater reliability of .43 (two raters). Because families are the object of assessment, the interrater reliability is more revealing about the dependability of the instrument than are individual-level alphas.
Evidence of Criterion-Related Validity	Families with a history of alcoholism and an alcoholic family member had significantly higher Conflict scale scores. Correlations of .34 and .48 have been found between the Conflict scale and self-reported drinking problems and alcohol consumption, respectively.

**Evidence of
Appropriateness for
Different Groups**

Moos and Moos (1986) used a sample that included single-parent and multi-generational families from several ethnic groups. The FES has been used in analyses examining predominantly African-American and Latino samples. In those studies that report reliability separately for male and female respondents, reliability coefficients were similar for males and females. The FES has been translated and adapted for use in a number of European, Asian, and African countries.

References

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Family Processes:

Measure 33

Title:

Conflict Tactic Scale (CTS)

Ages: adolescents, adults

Scales: Verbal Aggression
Violence

Author:

Murray A. Straus

How To Obtain

Contact Murray A. Straus, Family Research Laboratory, University of New Hampshire, Durham, NH 03824. Phone: (603) 862-1888.

Cost The CTS scales, a manual, and related materials are available from the author. A manual costs \$25; one copy of Form A costs \$2; and one copy of Form N costs \$1.

Ages The CTS was originally intended to be administered to two adults (husband/wife, or couple), but it has also been successfully used with adolescents and adults in assessing parent-child conflict. Adolescents are able to respond to questions regarding techniques used during conflicts between themselves and their parents.

Content The CTS asks questions about the frequency with which particular techniques are used during a conflict between a husband and a wife. The instrument, designed to be administered to adults, is available in both interview and questionnaire formats. The questionnaire (Form A) has 14 items. Items ask about the frequency with which the spouse (for example) “Discussed the issue relatively calmly” (Verbal Aggression scale) and “Pushed, grabbed, or shoved [the spouse]” (Violence scale). The interview (Form N) has 19 items. The respondent is first asked to answer how often *the respondent* employed the particular conflict tactic in the past year. The respondent is then asked how often *the respondent's spouse* used the particular conflict tactic in the past year. Items from the interview include “Did or said something to spite the other one” (Verbal Aggression scale) and “Kicked, bit, hit with fist” (Violence scale).

Time and Special Arrangements The Form A (questionnaire) CTS takes 5 to 10 minutes to administer. The Form N (interview) takes approximately 30 minutes. A Spanish translation of Form N is available.

Evidence of Reliability For the Verbal Aggression scale, alphas ranging from .79 to .81 have been reported, and interrater agreement correlations of .51 and .43 have been found. Alpha coefficients reported for the Violence scale have ranged from .82 to .92, and interrater agreement correlations have ranged from .26 to .65, with a median of .64.

**Evidence of
Criterion-Related
Validity**

Straus (1979) showed when holding the child's age, sex, and family socioeconomic status constant, verbal aggression and violence toward the child (parent-child conflict) was significantly related to child aggression and delinquency. In a second study the same Straus report demonstrated that the Verbal Aggression scale score significantly differentiated aggressive and non-aggressive institutionalized individuals, and a third study of Black male adolescents showed that verbal aggression scores were highly associated with measures of physical aggression toward friends and strangers. Correlations between self-report aggression and the Violence subscale ranged from .37 to .53, with a median of .46. Correlations between self-report aggression and the Verbal Aggression subscale ranged from .37 to .46, with a median of .42.

**Evidence of
Appropriateness for
Different Groups**

Comparable alphas have been reported for women rating male partners and men rating female partners. Straus reported alphas of .82 and .83 for the Violence subscale and .79 and .80 for the Verbal Aggression subscale. Spanish-language translations have been used in research, but psychometric information has apparently not been reported for any specific ethnic group. Most studies using the CTS either employed samples that were predominantly White or did not provide ethnic breakdowns. CTS has been used with male and female samples consisting of White, African-American, and "other" (not specified) ethnic groups.

References

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Family Processes:

Measure 34

Title:

O'Leary Porter Scale (OPS)

Ages: adult

Scale: Instrument is used in its entirety

Authors:

Beatrice Porter and K. Daniel O'Leary

How To Obtain

Contact K. Daniel O'Leary or Beatrice Porter, Department of Psychology, State University of New York at Stony Brook, Stony Brook, NY 11794. Phone: (516) 632-7850.

Cost The items appear in the source document, but the instrument, which includes the response format, is available from the authors. Users must reproduce and score the instrument themselves.

Ages The OPS was developed as a measure for adults. The scale can be used to measure marital or partner hostility in order to assess its effect on children.

Content The OPS contains 10 items asking parents how often various forms of parental hostility (e.g., quarrels, sarcasm, physical abuse) are observed by the child. One sample item is "How often do you and/or your spouse display verbal hostility in front of this child?" The items are rated along a five-point Likert-type scale ranging from "very often" to "never."

Time and Special Arrangements The OPS is brief (10 items) and consequently takes a short time to administer (5–10 minutes on average).

Evidence of Reliability The source document reported retest reliability of .96 for a 2-week interval. Other researchers have found an interrater reliability of .74 (mother and father) and an alpha coefficient of .81.

Evidence of Criterion-Related Validity Validity evidence consists of correlations between OPS and measures of problem behavior in children. Correlations between the OPS and children's conduct problems range from $-.21$ to $.44$, with a median of $.30$.

Evidence of Appropriateness for Different Groups Studies suggest that this measure is equally valid for assessing marital conflict in the homes of male and female children. Information is not available for different ethnic groups.

References

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Family Processes:

Measure 35

Title:

Conflict Behavior Questionnaire (CBQ) (called *Interaction Behavior Questionnaire for Clients*)

Author:

Ronald J. Prinz

Ages: 11–18

Scales: Adolescent Appraisal of Dyad (16 items)
Adolescent Appraisal of Parent (28 items)
Parent Appraisal of Dyad (16 items)
Parent Appraisal of Adolescent (28 items)

How To Obtain	Contact Ronald J. Prinz, Department of Psychology, University of South Carolina, Columbia, SC 29208. Phone: (803) 777-4137.
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Cost	Contact the author for information on cost.
Ages	The CBQ is designed to measure conflict between parents and adolescents (11 to 18 years of age).
Content	The CBQ is a 44-item, self-report survey instrument available in two versions: one is for assessments made by the adolescent, and one is for assessments made by the parent. The scales of the CBQ consist of statements to which the respondent answers “true” or “false.” Many of the adolescent and parent questions are the same but make reference to the other person. Questions typical of each scale are as follows: Adolescent Appraisal of Dyad—“We joke around often,” “My [parent] and I speak to each other only when we have to,” and “We almost never seem to agree.” Adolescent Appraisal of Parent—“If I run into problems, my mom helps me out,” “My mom gets angry at me whenever we have a discussion,” and “She makes me feel that the argument is all my fault.” Parent Appraisal of Dyad—“We argue at the dinner table at least half the time we eat together,” “In general, I don’t think we get along very well,” and “We do a lot of things together.” Parent Appraisal of Adolescent—“My child contradicts everything I say,” “My child often seems angry at me,” and “My child curses at me.”
Time and Special Arrangements	The entire instrument should take no more than 30 minutes to complete.
Evidence of Reliability	The authors reported alpha coefficients for the scales that ranged from .88 to .95. No information is available on interrater reliability or stability of scores over time (Prinz, Foster, Kent, & O’Leary, 1979).

Evidence of Criterion-Related Validity	All four scales of the CBQ distinguished mother-child dyads in which the mother had sought clinical assistance with the relationship from mother-child dyads who reported that they got along well.
Evidence of Appropriateness for Different Groups	The source document provided information on the total sample (approximately half males and half females) but did not provide information on the ethnicity of the sample. Subsequent studies using the CBQ have either not reported the ethnic composition or have used predominantly White samples.
References	Prinz, R. J., Foster, S. L., Kent, R. N., & O'Leary, K. D. (1979). Multivariate assessment of conflict in distressed and nondistressed mother-adolescent dyads. <i>Journal of Applied Behavior Analysis</i> , 12(4), 691–700.(*)

Family Processes:

Measure 36

Title:

What About You (WAY), Forms C and E

Ages: 9–10 (Form E)
11–18 (Form C)

Scale: Parental Supervision

Authors:

Gary D. Gottfredson and Denise C. Gottfredson

How To Obtain	Contact Gary Gottfredson, Gottfredson Associates, Inc., 3239B Corporate Court, Ellicott City, MD 21041. Phone: (410) 461-5530.
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Cost	Permission must be obtained to use the WAY questionnaire. Assessment booklets, which are reusable for Form C, cost \$.85 to \$1.00 apiece, depending on the quantity ordered. Answer sheets cost \$.08 or \$.09 each. Scoring costs vary depending on the form and the quantity. Form C answer sheets are scanned and scored for \$.25 each. Form E booklets are keyboarded and scored for \$1.45 each.
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Ages	Form C is intended for use with students in grades 6 through 12 (ages 11 through 18) and Form E is intended for use with students in grades 4 and 5 (ages 9 and 10).
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Content	WAY is a self-report questionnaire that assesses a variety of individual, peer, and family risk factors for problem behavior. Question formats include true-false and Likert-type scales. WAY is available in two forms: a 184-item Form C, intended for youth in grades 6 through 12, and a 114-item Form E, intended for youth in grades 4 and 5. The parental supervision scale in Form C has 16 items. The Form E scale has 12 items. "My parents keep close track of how well I am doing in school" and "My parents usually don't know what I do after school" are typical of the items in both forms.
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Time and Special Arrangements	The entire WAY questionnaire takes approximately 50 minutes to complete and is usually administered in a classroom environment. Administration instructions are provided, along with the survey booklets. Optically scannable answer sheets are available for use with Form C. A scoring service is available.
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Evidence of Reliability	Gottfredson and Gottfredson (1992a) reported alpha coefficients for the Form C Parental Supervision scale from .72 to .81, with a median of .78. One-year retest reliabilities ranged from .48 to .64, median = .57. For Form E, alphas ranged from .62 to .74 (median = .74), and a 1-year retest correlation of .66 was reported.
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Evidence of Criterion-Related Validity	<p>For Form C, correlation coefficients for the Parental Supervision scale and various measures of substance abuse in the last year ranged from $-.24$ to $-.50$. One-year predictive correlations of the Form C scale with school records (absences, suspensions, and disciplinary referrals) ranged from $-.10$ to $-.30$. For Form E, correlation coefficients reported for the Parental Supervision scale and various measures of substance abuse ranged from $-.11$ to $-.31$.</p>
Evidence of Appropriateness for Different Groups	<p>Reliability and validity evidence for Form C for four different subgroups (African-American males and females and European-American males and females) was examined (Gottfredson & Gottfredson, 1992a). The data showed similar alphas for the different subgroups. Although there are no meaningful race or gender differences in correlations of Parental Supervision (Form C) and Rebellious Behavior, parental supervision was more highly correlated with substance abuse for European Americans than for African Americans ($-.30$ for African-American and $-.47$ for European-American boys). Gottfredson and Koper (1996) showed that the Parental Supervision scale predicts the number of different substances used in the next year equally well for members of the four subgroups, but it predicts the frequency of substance abuse in the next year less well for African-American females than for the other three groups.</p>
References	<p>Gottfredson, D. C., & Koper, C. S. (1996). Race and sex differences in the prediction of drug use. <i>Journal of Consulting and Clinical Psychology</i>, 64, 305–313.(*)</p> <p>Gottfredson, G. D., & Gottfredson, D. C. (1992a). <i>Development and applications of theoretical measures for evaluating drug and delinquency prevention programs</i>. Paper presented at the annual meeting of the American Society of Criminology, New Orleans.(*)</p> <p>Gottfredson, G. D., & Gottfredson, D. C. (1992b). <i>What About You Forms C and E, research editions: Supplementary information</i>. Ellicott City, MD: Gottfredson Associates, Inc.(*)</p>

Family Processes:

Measure 37

Ages: 12–19

Title:

Scale: Control and Supervision

Family Instrument

Authors:

Stephen A. Cernkovich and Peggy C. Giordano

How To Obtain	The Family Instrument items are listed in the source document, but permission should be obtained from Stephen Cernkovich or Peggy Giordano, Department of Sociology, Bowling Green State University, Bowling Green, OH 43403. Phone: (419) 372-2294.
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Cost	Contact the author for information on cost.
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Ages	The Family Instrument is intended for use with adolescents and young adults (ages 12–19).
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Content	The Family Instrument is an interview schedule composed of 28 items using a five-point Likert-type format. The Control and Supervision scale has three items. Examples are “In my free time away from home, my parents know who I’m with and where I am” and “My parents want me to tell them where I am if I don’t come home right after school.”
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Time and Special Arrangements	The family relations survey takes approximately 20 minutes to administer.
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Evidence of Reliability	The source document reported an alpha of .69 (Cernkovich & Giordano, 1987).
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Evidence of Criterion-Related Validity	The source document reported that the Control and Supervision scale had a correlation of $-.18$ with self-reported delinquency.
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Evidence of Appropriateness for Different Groups	No reliability or validity data were available for specific gender or ethnic groups. The sample used in the source document was approximately half male, half female with equal numbers of White and African-American youth.
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References	Cernkovich, S. A., & Giordano, P. C. (1987) Family relationships and delinquency. <i>Criminology</i> , 25(2), 295–321.(*)
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Family Processes:
Measure 38

Title:

The Oregon Youth Study

Author:

Gerald Patterson

Ages: grades 4–12

Scales: Monitoring—Mother
Report
Monitoring—Child Report
Monitoring—Supervision
Hours
Discipline—Mother
Report

How To Obtain Questions are listed in the referenced sources except for the Mother Report Discipline scale. Questions for the Mother Report Discipline scale can be obtained by contacting Oregon Social Learning Center, 207 East 54th Ave., Suite 202, Eugene, OR 97401. Phone: (541) 485-2711.

Cost The author should be contacted to determine if costs beyond composition, duplication, and scoring by the user are associated with their use.

Ages The measures listed above have been used with male youth in grades 4 through 12 in an ongoing longitudinal study called the Oregon Youth Study.

Content Researchers at the Oregon Social Learning Center have developed several measures of parental monitoring and discipline. Their primary measures of discipline for use in research are based on home observations; these are described elsewhere (Patterson, Reid, & Dishion, 1992). The interview measures of monitoring and discipline are based on parent reports, child reports, and differences between reports of mothers and their children. The Mother Report Monitoring scale used in Patterson and Dishion (1985) is based on the mother’s response to two interview items: (1) “How important do you think it is to know where your child is?” and (2) “Where does your child usually go after school?” The Child Report of monitoring used by Patterson and Dishion is based on the child’s response to five interview items. Examples are “How often do your parents know where you are when you are not in school?” and “Is it important for your parents to know where you are all the time?” The Supervision Hours Monitoring score is the average number of unsupervised hours based on five phone interviews. It is calculated by adding together the hours spent unsupervised (during the 5 days the phone interviews take place) and dividing the total number of unsupervised hours by five (Patterson & Bank, 1986). The Mother Report Discipline scale is based on the mother’s response to six questions. Examples are “If you tell your son he will get punished if he doesn’t stop doing something, how often will you punish him?”; “How often do you get angry when you punish your son?”; and “How often do you feel you are having problems managing your son in general?” Responses range from “never” to “always.”

Time and Special Arrangements

These scales were originally part of a half-hour structured interview. However, the items mentioned above should take only minutes to complete.

Evidence of Reliability

The two-item measure of mother's monitoring and the five-item Child Report Monitoring scale have obtained 90 percent agreement between coders (Patterson & Dishion, 1985). The Supervision Hours Monitoring score had a retest reliability of .50, (Patterson & Stouthamer-Loeber, 1984), and the Mother Report Discipline scale has had alphas of .17 and .74.

Evidence of Criterion-Related Validity

Correlations between the Monitoring and Discipline scales and police contacts were $-.23$ and $-.30$. Correlations between the Monitoring and Discipline scales and ratings of problem behavior range from $.03$ to $-.18$, with a median of $-.12$.

Evidence of Appropriateness for Different Groups

Studies using the measures listed above have used predominantly White and all male samples. Reliability and validity evidence has not been established for females or different ethnic groups. The studies reviewed tended to report higher criteria in correlations for older adolescents. Boys in grade 4 were involved in the study, with weak correlations between monitoring and antisocial behavior. Boys in grades 7 and 10 were examined in the studies showing moderate to strong correlations between delinquency, police contacts, and supervision or discipline.

References

- Capaldi, D. M., & Patterson, G. R. (1989). *Psychometric properties of fourteen latent constructs from the Oregon Youth Study*. New York: Springer-Verlag.(*)
- Patterson, G. R., & Bank, L. (1986). Bootstrapping your way in the nomological thicket. *Behavioral Assessment*, 8, 49–73.(*)
- Patterson, G. R., & Dishion, T. J. (1985). Contributions of families and peers to delinquency. *Criminology*, 23(1), 63–80.(*)
- Patterson, G. R., Reid, J. B., & Dishion, T. J. (1992). *A social interactional approach: Volume 4. Antisocial boys*. Eugene, OR: Castalia Publishing Company.
- Patterson, G. R., & Stouthamer-Loeber, M. (1984). The correlation of family management practices and delinquency. *Child Development*, 55, 1299–1307.(*)

Family Processes:

Measure 39

Title:

Parenting Scale

Ages: adult

Scales: Lax Discipline
Overreactivity

Authors:

David S. Arnold, Susan G. O'Leary, Lisa S. Wolff, and
Maureen M. Acker

How To Obtain

Send a self-addressed stamped envelope to Susan G. O'Leary, Department of Psychology, State University of New York at Stony Brook, Stony Brook, NY 11794-2500. Phone: (516) 632-7833.

Cost

Contact the author for information on cost.

Ages

The Parenting Scale is intended for adults (parents).

Content

The Parenting Scale is a 30-item survey in which the parents are presented with a problem and asked to pick a response that best characterizes their reaction to that particular problem. The most and least effective responses anchor the ends of the scale. The Lax Discipline scale has 11 items. A sample item and response are "When I say my child can't do something . . . I stick to what I said" (most effective) and "I'll let my child do it anyway" (least effective). Another item in the Lax Discipline scale is "If my child gets upset when I say no . . . I stick to what I said" (most effective) and "I'll back down and give in to my child" (least effective). The Overreactivity scale has 10 items. A sample item and response are "After there is a problem with my child . . . things get back to normal quickly" (most effective) and "I'll often hold a grudge" (least effective). Another item from the Overreactivity scale is "When my child does something I don't like, I insult my child, say mean things, or call my child names," with the most effective response "rarely or never" and the least effective response "most of the time."

Time and Special Arrangements

The Parenting Scale takes approximately 20 minutes to administer.

Evidence of Reliability

The source document reported an alpha of .83 and a retest coefficient of .83 for the Lax Discipline scale and an alpha of .82 and a retest coefficient of .82 for the Overreactivity scale.

Evidence of Criterion-Related Validity

The source document reported a correlation of .41 between the Lax Discipline scale and parent reports of child problem behavior and .54 between Overreactivity and parent reports of child problem behavior.

**Evidence of
Appropriateness for
Different Groups**

Reliability and validity data reported by the source document were for an all-female sample. Because the Parenting scale is relatively new, information about reliability and validity for males and various ethnic groups is not now available.

References

Arnold, D. S., O Leary, S. G., Wolff, L. S., & Acker, M. M. (1993). The Parenting Scale: A measure of dysfunctional parenting in discipline situations. *Psychological Assessment*, 5(2), 137–144. (*)

Family Processes:

Measure 40

Ages: 12 and older

Title:

Scale: Affective Responsiveness

McMaster Family Assessment Device (FAD)

Author:

Nathan Epstein

How To Obtain	FAD questions are listed in Epstein et al. (1983) but permission should be obtained from Dr. Nathan Epstein, Family Research Program, Brown University, Butler Hospital, 345 Blackstone Boulevard, Providence, RI 20906.
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Cost	Contact the author for information on cost.
Ages	The FAD can be completed by family members over the age of 12. Scores from assessments by these family members can be related to problem behavior of younger family members.
Content	The FAD is a 53-item pencil-and-paper questionnaire. Items are scored on a four-point Likert-type scale ranging from “strongly agree” to “strongly disagree.” Sample items on the Affective Responsiveness scale are “We express tenderness” and “We cry openly.”
Time and Special Arrangements	The FAD takes 30 to 60 minutes to administer.
Evidence of Reliability	The source document reported an alpha of .83. Additional studies have found alpha coefficients ranging from .73 to .83, a retest reliability of .76, and inter-rater agreements of .30, and .43 (two raters).
Evidence of Criterion-Related Validity	Criterion validity has been demonstrated in several studies. A correlation of $-.50$ was found between the Affective Responsiveness scale and a measure of anger-hostility. In another study, this scale was associated with the quantity and frequency of beer ($r = -.50$), wine ($r = -.22$), and liquor ($r = -.49$), and the frequency of marijuana ($r = -.26$) use.

Evidence of Appropriateness for Different Groups

Most of the studies reviewed did not specify the sample's ethnicity. The studies that did mention ethnicity were largely made up of European Americans. Although the FAD has been used with males and females, separate psychometric information was not provided. The FAD has been used in research conducted in the Netherlands (with a Dutch version) and England. Attempts have also been made to use the FAD in Australia, Great Britain, Hungary, Italy, and South Africa.

References

- Akister, J., & Stevenson-Hinde, J. (1991). Identifying families at risk: Exploring the potential of the McMaster Family Assessment Device. *Journal of Family Therapy*, 13, 411-421.(*)
- Epstein, N. B., Baldwin, L. M., & Bishop, D. S. (1983). The McMaster Family Assessment Device. *Journal of Marital and Family Therapy*, 9(2), 171-180.(*)
- Kabacoff, R. I., Miller, I. W., Bishop, D. S., Epstein, N. B., & Keitner, G. I. (1990). A psychometric study of the McMaster Family Assessment Device in psychiatric, medical, and nonclinical samples. *Journal of Family Psychology*, 3, 431-439.(*)
- McKay, J. R., Maisto, S. A., Beattie, M. C., Longabaugh, R., & Noel, N. E. (1993). Differences between alcoholics and spouses in their perceptions of family functioning. *Journal of Substance Abuse Treatment*, 10, 17-21.(*)
- McKay, J. R., Murphy, R. T., Rivinus, T. R., & Maisto, S. A. (1991). Family dysfunction and alcohol and drug use in adolescent psychiatric inpatients. *Journal of American Academy of Child and Adolescent Psychiatry*, 30(6), 967-972.(*)
- Wenniger, W. F., Hageman, W. J., & Arrindell, W. A. (1992). Cross-national validity of dimensions of family functioning: First experiences with the Dutch version of the McMaster Family Assessment Device (FAD). *Personality and Individual Differences*, 14(6), 769-781.(*)

Family Processes:

Measure 41

Ages: 10–18

Title:

Scale: Acceptance

**Children’s Report on Parent Behavior
(CRPBI B-30)**

Authors:

Edward Schludermann and Shirin Schludermann

How To Obtain	Contact Edward Schludermann & Shirin Schludermann, Department of Psychology, University of Manitoba, Winnipeg, Manitoba, Canada R3T 2N2. Phone: (204) 474-9617.
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Cost	Contact the authors for information on cost.
Ages	The CRPBI B-30 was developed for use with children and adolescents ages 10 to 18.
Content	The CRPBI is a questionnaire assessing a child’s impression of his or her parents’ behavior. CRPBI B-30 is composed of 30 questions and has a version assessing the mother’s and father’s behavior. The CRPBI assesses parental behavior by making a statement describing a parent’s behavior and asking the child to reply whether the behavior is not like, somewhat like, or a lot like the parent. The Acceptance scale has 10 items. Sample items are “My [parent] is a person who . . . makes me feel better after talking over my worries with [him or her],” “Smiles at me very often,” and “Is able to make me feel better when I am upset.”
Time and Special Arrangements	The CRPBI B-30 should take approximately 15 minutes to complete, with more or less time needed depending on the child’s age and reading level.
Evidence of Reliability	The authors reported retest reliabilities ranging from .84 to .89 and alpha coefficients ranging from .73 to .75 (Schludermann & Schludermann, 1988).
Evidence of Criterion-Related Validity	Evidence of criterion-related validity (i.e., correlations between these measures and some form of problem behavior) have not been reported. The content of the scales suggests that they measure parental support and attachment at least as well as shorter scales for which validity evidence is available.

**Evidence of
Appropriateness for
Different Groups**

Information about reliability or validity is not available for different ethnic or gender groups. The CRPBI has been used mostly with White or predominantly White samples, but African-American, Latin-American, Hutterite, Korean, and English-speaking adolescents in India have also completed the CRPBI.

References

Schludermann, E. H., & Schludermann, S. M. (1988). *Children's Report on Parent Behavior (CRPBI-108, CRPBI-30) for older children and adolescents* (Technical Report) Winnipeg, MB, Canada: University of Manitoba, Department of Psychology.(*)

Family Processes:

Measure 42

Title:

Family Environment Scale (FES), Form R

Ages: 11 and older

Scale: Cohesion

Authors:

Rudolph H. Moos and Bernice S. Moos

How To Obtain

Contact Consulting Psychologists Press, Inc., 3803 E. Bayshore Rd., Palo Alto, CA 94303. Phone: (800) 624-1765.

Cost Manual costs \$35; Form R, \$17 (25 forms); self-scoring answer sheets, \$25 (25 sheets); scoring key, \$9.50; report forms, \$21 (25 forms); profile sheets, \$6 (25 sheets).

Ages The FES is intended for adults and children 11 years of age and older.

Content The FES is a 90-item, true-false self-report questionnaire that assesses the social environment characteristics of families. The Cohesion scale is made up of nine items. Sample items are "Family members really help and support one another" and "There is a feeling of togetherness in our family."

Time and Special Arrangements The authors suggest that the FES be administered in a quiet, comfortable, well-lit room with ample space for each respondent to work. The Cohesion scale scores can be based on reports from all family members and averaged together. However, many studies have based the FES score on the perception of only one family member. The entire instrument takes 15–20 minutes to complete. Therefore, this scale should take 5 minutes or less to complete.

Evidence of Reliability The authors reported an alpha of .78 for the Cohesion scale, 2-month, 4-month, and 12-month retest reliabilities of .86, .72, and .63, respectively (Moos & Moos, 1986). More recently they have reported 1-year and 3 - to 10-year retest correlations ranging from .51 to .58 for *individuals* living in the same families at the beginning and end of the intervals (Moos & Moos, 1994). Other studies produced alphas ranging from .69 to .89. Interrater reliability coefficients or intraclass correlations, which would provide the most important reliability information by showing whether different observers tend to agree on the description of families, are not reported in the manuals.

Evidence of Criterion-Related Validity	Families with a history of alcoholism and an alcoholic family member had significantly lower Cohesion scale scores. Correlations of $-.32$ and $-.37$ have been found between the Cohesion scale and self-reported drinking problems and alcohol consumption, respectively.
Evidence of Appropriateness for Different Groups	Moos and Moos (1986) used a sample that included single-parent and multi-generational families from several ethnic groups, and the 1994 manual reports means for families of different size. The 1994 manual also reports normative information for a sample of middle-class African-American adolescents. The FES has been used with both males and females, and Moos and Moos (1994) say that "gender differences have little impact on perceptions of family environment" (p. 25). Separate sex norms are not provided. The FES has been translated and adapted for use in a number of European, Asian, and African countries.
References	<p>Barry, K. L., & Fleming, M. F. (1990). Family cohesion, expressiveness and conflict in alcoholic families. <i>British Journal of Addiction</i>, 85, 81–87.(*)</p> <p>Bloom, B. L. (1985). A factor analysis of self-report measures of family functioning. <i>Family Process</i>, 24(2), 225–239.(*)</p> <p>Cheung, P. C., & Law, S. (1985). Self-esteem: Its relationship to the family and school social environments among Chinese adolescents. <i>Youth and Society</i>, 16(4), 438–456.(*)</p> <p>Ma, H. K., & Leung, M. C. (1990). The adaptation of the Family Environment Scale to Chinese children and adolescents in Hong Kong. <i>International Journal of Psychology</i>, 25(4), 545–555.(*)</p> <p>Moos, R. H., & Moos, B. S. (1986). <i>Family Environment Scale manual</i> (2nd ed.). Palo Alto, CA: Consulting Psychologists Press.</p> <p>Moos R. H., & Moos, B. S. (1994). <i>Family Environment Scale manual</i> (3rd ed.). Palo Alto, CA: Consulting Psychologists Press.(*)</p>

Family Processes:

Measure 43

Title:

Family Instrument

Ages: 12–19

Scales: Caring and Trust
Identity Support

Authors:

Stephen A. Cernkovich and Peggy C. Giordano

How To Obtain	Permission to use the scales should be obtained from Stephen Cernkovich or Peggy Giordano, Department of Sociology, Bowling Green State University, Bowling Green, OH 43403. Phone: (419) 372-2294. Items are listed in the source document, but the instrument must be reproduced and scored by the user.
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Cost	Contact the author for information on cost.
Ages	The Family Instrument is intended for use with adolescents and young adults ages 12–19.
Content	The Family Instrument is an interview schedule composed of 28 items with a five-point Likert-type format. The Caring and Trust scale has six items. Examples are “My parents trust me” and “I’m closer to my parents than a lot of kids my age are.” The Identity Support scale has four items. Examples are “My parents seem to wish I were a different type of person” and “My parents sometimes give me the feeling that I’m not living up to their expectations.”
Time and Special Arrangements	The Family Instrument takes approximately 20 minutes to administer.
Evidence of Reliability	The source document reported an alpha of .76 for the Caring and Trust scale and .69 for the Identity Support scale (Cernkovich & Giordano, 1987).
Evidence of Criterion-Related Validity	Correlations with self-reported delinquency were $-.19$ for the Caring and Trust scale and $-.22$ for the Identity Support scale.
Evidence of Appropriateness for Different Groups	No reliability or validity data were available for specific gender or ethnic groups. The sample used in the source document was approximately half male and half female and made up of both White and African-American youth.
References	Cernkovich, S. A., & Giordano, P. C. (1987). Family relationships and delinquency. <i>Criminology</i> , 25, 295–321.(*)

Family Processes:

Measure 44

Ages: 12 and older

Title:

Scale: Cohesion

Family Adaptability and Cohesion Evaluation Scales B II (FACES II)

Author:

David Olson

How To Obtain

The FACES II instrument may be obtained by calling (602) 625-7250 or writing Family Inventory Project (FIP), Family Social Science, University of Minnesota, 290 McNeal Hall, St. Paul, MN 55108. A publication containing abstracts of more than 600 studies completed using the FACES instruments is also available.

Cost

The instrument costs \$30. Shipping and handling is an additional \$5.

Ages

FACES II is intended for children as young as 12 and for adults (including adults with limited reading ability).

Content

FACES II is a 30-item self-report questionnaire. It measures two family dimensions: Cohesion and Adaptability. The Cohesion subscale appears to tap the family support and attachment construct identified in Part I. The individual items are scored on a five-point Likert-type scale ranging from "almost never" to "almost always." Items measuring cohesion include "Family members feel very close to each other" and "Family members like to spend their free time with each other."

Time and Special Arrangements

FACES II takes 10 to 15 minutes to administer.

Evidence of Reliability

The source document reported an alpha of .87 (Olson et al., 1983), and other studies have reported alphas ranging from .77 to .79. A retest correlation of .83 and interrater correlations ranging from -.03 to .50 (median = .34) have been reported.

Evidence of Criterion-Related Validity

The Cohesion subscale was negatively associated ($r = -.20$) with mother ratings of child behavior problems.

**Evidence of
Appropriateness for
Different Groups**

FACES II has been used with samples of various ethnic groups (European Americans, Latin Americans, and African Americans) and both genders. About 50 studies were completed using FACES II with various ethnic groups, but reliability information is reported only for European and Hispanic Americans.

References

- Draper, T. W., & Marcos, A. C. (Eds.). (1990). *Family variables: Conceptualization, measurement, and use*. Newbury Park, CA: Sage Publications.(*)
- Friedman, A. S., Utada, A., & Morrissey, M. R. (1987). Families of adolescent drug abusers are “rigid”: Are these families either “disengaged” or “enmeshed” or both? *Family Process*, 26(1), 131–148.(*)
- Olson, D. H., McCubbin, H. I., Barnes, H., Larsen, A., Muxen, M., & Wilson, M. (1983). *Families, what makes them work?* Beverly Hills, CA: Sage Publications.(*)
- Vega, W. A., Patterson, T., Sallis, J., Nader, P., Atkins, C., & Abramson, I. (1986). Cohesion and adaptability in Mexican-American and Anglo families. *Journal of Marriage and the Family*, 48, 857–867.(*)
- Watson, S. M., Henggeler, S. W., & Whelan, J. P. (1990). Family functioning and the social adaptation of hearing-impaired youth. *Journal of Abnormal Child Psychology*, 18(2), 143–163.(*)

Family Processes:

Measure 45

Ages: 11–18

Title:

Scale: Family Attachment

Communities That Care Youth Survey

Authors:

Michael Arthur, John A. Pollard, J. David Hawkins, and
Richard F. Catalano

How To Obtain	Contact Customer Service, Developmental Research and Programs, Inc., 130 Nickerson St., #107, Seattle, WA 98119. Phone: (206) 286-1805, Fax: (206) 286-1462.
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Cost	Cost is \$1.80 per survey form. There are additional costs (\$300–\$625) for analysis and report generation. For an additional fee, the survey can be customized to better meet individual users' needs.
Ages	The survey instrument is appropriate for ages 11 through 18 (grades 6–12).
Content	The Communities That Care Youth Survey contains 201 items. It includes scales measuring substance abuse; demographic characteristics; and community, family, school, peer, and individual factors related to substance abuse. The Family Attachment scale is made up of six questions, such as "Do you feel close to your mother [father]?" and "Do you share your thoughts and feelings with your mother [father]?" Response categories are "NO!" "no," "yes," and "YES!"
Time and Special Arrangements	The entire survey instrument is designed to be administered in a single class period of 45 minutes to 1 hour. The Family Attachment scale contains only six items, so would take much less time. Administration instructions are provided by Developmental Research and Programs, Inc. (DRP). The survey is provided on an optically scannable form. Completed surveys are returned to DRP for scoring, development of the data base, analysis, and report generation. The survey organizer is responsible for administration and return of the completed surveys to DRP.
Evidence of Reliability	The authors have provided unpublished tabulations indicating a Cronbach's alpha of .84 for the Family Attachment scale (M. Arthur, personal communication, 1994).

**Evidence of
Criterion-Related
Validity**

Correlations with substance abuse range from $-.10$ to $-.23$.

**Evidence of
Appropriateness for
Different Groups**

The data presented above were obtained from a sample consisting mostly of White adolescents. Detailed analysis of survey appropriateness has not been attempted for specific minority populations.

References

This is a recently developed instrument. A manual is not available. Contact John Pollard with questions at (206) 286-1805.

Substance Abuse:

Measure 46

Title:

National Youth Survey (NYS)

Author:

Delbert S. Elliott

Ages: 11 and older

Scales: Alcohol Use
Marijuana Use
Illicit Drug Use

How To Obtain	Contact Dr. Delbert Elliott, Institute of Behavioral Science, University of Colorado, Campus Box 483, Boulder, CO 80309. Phone: (303) 492-1266.
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Cost	Contact the author.
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Ages	The National Youth Survey is intended for use with youth aged 11 through adult.
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Content	The NYS is an interview used in a national longitudinal study examining delinquency, substance abuse, demographics, and several domains of risk and protection: community, family, work, school, peer, and individual behaviors and attitudes related to delinquency and substance abuse among U.S. youth. It measures several of the factors related to substance abuse covered in this guide. In the scales measuring substance abuse, respondents indicate the number of times ("never," "once or twice," or "once every 2–3 months") they have used each of the following substances in the past year: alcohol, marijuana, hallucinogens, amphetamines, barbiturates, heroin, and cocaine. If the substance was used 10 times or more, an expanded frequency of use question is also asked: response categories range from "once a month" to "2–3 times a day." Separate scales are created for alcohol use, marijuana use, and illicit substance abuse.
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Time and Special Arrangements	The NYS is a face-to-face interview, but its alcohol- and substance-related items can also be used in a written survey format. The substance abuse scales should take only minutes to complete. Administration instructions for the entire NYS interview are available from the authors.
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Evidence of Reliability	Elliott and Huizinga (1984) reported that the alpha reliabilities for all scales in the National Youth Survey were greater than .60.
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**Evidence of
Criterion-Related
Validity**

Elliott, Huizinga, and Menard, (1989) reported that extensive analyses of all self-report items in the NYS, including comparisons of self-reported offenses with arrest records, supported the validity of the substance use measures. In addition, alcohol and marijuana prevalence rates (e.g., the proportion of respondents reporting alcohol and marijuana use) from the NYS were not found to be significantly different from those obtained in the Monitoring the Future study.

**Evidence of
Appropriateness for
Different Groups**

The NYS was used with a nationally representative sample, but reliability and validity evidence has not been reported for separate gender or ethnic groups. Elliott and Huizinga (1984) state, however, that reliabilities are “adequate to excellent for the total sample and all demographic subgroups.”

References

- Elliott, D. S., & Huizinga, D. (1984). *The relationship between delinquent behavior and ADM problems*. Boulder, CO: Behavioral Research Institute.
- Elliott, D. S., Huizinga, D., & Menard, S. (1989). *Multiple problem youth: Delinquency, substance use, and mental health problems*. New York: Springer-Verlag.

Substance Abuse:

Measure 47

Title:

Monitoring the Future (MTF)

Ages: grade 8–college and young adult

Scale: Drug Use Measures

Authors:

Lloyd D. Johnston, Jerald G. Bachman, and Patrick M. O'Malley

How To Obtain

Contact Dr. Lloyd D. Johnston, Institute for Social Research, University of Michigan, Ann Arbor, MI 48106. Phone: (313) 763-5043. One of the MTF instruments appears in the appendix of Hawkins, J.D., and Nederhooft, B. (1987), *Handbook for evaluating drug and alcohol prevention programs: Staffteam evaluation of prevention programs (STEPP)*. (DHHS Publication No. ADM 87-1512, Rockville, MD: Office for Substance Abuse Prevention). The forms for the 8th and 10th grade surveys are available on the World Wide Web at www.icpsr.umich.edu/SAMHDA/mtf.html

Cost Single copies can be obtained at no cost; the instruments are in the public domain. No services are provided by the authors, and multiple copies of the forms are not available for use.

Ages Fourteen different MTF survey forms exist for use with students in grades 8 through 12, as well as college students and young adults.

Content The MTF survey is a self-report questionnaire available in several different forms, each containing different sets of items and designed for different age groups. Six forms are available for use with college students and young adults, six for students in grade 12, and two for students in grades 8 and 10. Users are encouraged to choose those questions most appropriate to their work. Many variables are common to more than one form, and many (e.g., substance abuse measures) appear on all forms for a given grade level. Each form contains 300–350 variables measured by approximately 100 questions on approximately 12 pages. Each form measures substance abuse, demographic characteristics, and risk and protective factors in the following domains: community (e.g., substance availability), school, peer, and individual.

The Drug Use Measures scale contains 17 items, with most items containing three parts. The majority of the items ask about the frequency of cigarette, alcohol, and substance use/abuse. Items include “How frequently have you smoked cigarettes during the past 30 days?” and “On how many occasions have you had alcoholic beverages to drink in your lifetime . . . during the last 12 months . . . during the last 30 days?” The second question structure is used for marijuana, LSD, other psychedelics, cocaine (or crack cocaine), amphetamines, Quaaludes, barbiturates, tranquilizers, heroin, other narcotics (such as

opium, codeine), inhalants, and steroids. Response categories include 0 occasions, 1–2 occasions, 3–5, 6–9, 10–19, 20–39, and 40 or more occasions.

Time and Special Arrangements	Each MTF form can be completed in 45–50 minutes. The Substance abuse questions should take no more than 15 minutes to complete. The survey is printed on an optically scannable form.
Evidence of Reliability	O'Malley, Bachman, and Johnston, (1983) reported reliability coefficients separately for the cigarette, alcohol, and marijuana and illicit substance abuse scales. One-year retest correlations ranged from .83 to .89 for cigarette use, from .74 to .83 for alcohol use, from .71 to .90 for marijuana abuse, and from .58 to .77 for illicit substance abuse.
Evidence of Criterion-Related Validity	Cigarette and alcohol use/abuse and marijuana and other illicit substance abuse was correlated between .25 and .40 with truancy self-reports.
Evidence of Appropriateness for Different Groups	The MTF survey has been used with a nationally representative sample, but reliability and validity evidence was not reported for separate gender and ethnic groups.
References	O'Malley, P. M., Bachman, J. G., & Johnston, L. D. (1983). Reliability and consistency in self-reports of drug use. <i>International Journal of the Addictions</i> , 18(6), 805–824.

Substance Abuse:

Measure 48

Title:

American Drug and Alcohol Survey (ADAS)

Authors:

E. R. Oetting, F. Beauvais, and R. Edwards

Ages: grades 4–6 (child)
grades 7–12 (adol)

Scales: Alcohol
Marijuana
Cocaine
Inhalants
Amphetamines
Depressants
Heroin
LSD
PCP
Drug Involvement

How To Obtain	Contact RMBSI, Inc., 419 Canyon Avenue, Suite 316, P.O. Box 1066, Fort Collins, CO 80522. Phone: (800) 447-6354.
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Cost	The ADAS costs \$1 per survey with discounts for quantities greater than 800. Survey results are presented in a report for \$200 using the adolescent form and \$100 for the children's form.
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Ages	The adolescent form is designed for youth in grades 7 through 12, and the children's form is for youth in grades 4 through 6. The adolescent form of the ADAS is available in a Spanish-language version.
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Content	The ADAS is a self-report questionnaire available in two versions: the children's form (39 items) for youth in grades 4–6 and the adolescent form (57 items) for youth in grades 7–12. These forms measure substance abuse and specific substance abuse-related factors such as alcohol and substance availability, peer substance abuse, and perceived risk related to substance abuse. A second survey (entitled the Prevention Planning Survey), which consists of questions on other correlates of substance abuse (family, school, peer, and individual domains), is available from RMBSI, Inc. (see above). The Prevention Planning Survey is designed to be used with the adolescent form only.
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The adolescent form of the ADAS is made up of various substance abuse scales containing the following number of items: alcohol (10), marijuana (3), cocaine (5), inhalants (5), amphetamines (4), depressants (3), heroin (3), LSD (3), and PCP (3). Questions include "Have you ever tried any of the following drugs?" The respondent answers "yes" or "no" to a list of 14 substances. Other questions such as "Have you used any of these substances to get high during the last 12 months?" and "Have you used any of these substances to get high during the last month?" are also included. Referring to 12 types of substances, the last two questions have the following response categories: no, 1–2, 3–9, 10–19, or 20 or more times. Other questions ask about self-

identification as a user, from “non-user” to “very heavy user.” A score can also be obtained that classifies the adolescent in terms of overall level of involvement with substances. The children’s form is similar but contains items only on alcohol, tobacco, marijuana, inhalants, and “pills.”

Time and Special Arrangements

Contact RMBSI, Inc. (address above) for information and administration instructions. The ADAS takes 20 to 30 minutes to complete.

Evidence of Reliability

Cronbach’s alpha was reported for each substance scale and for five ethnic groups (White Americans, Mexican Americans, Native Americans, Black Americans, and Asian Americans) using youth in grades 6 through 12 (Oetting & Beauvais, 1990). The reliabilities were always above .7 for each substance and each group. Alpha coefficients for the children’s form were between .87 and .94 for alcohol, marijuana, and inhalant use (Oetting, Edwards, & Beauvais, 1985).

Evidence of Criterion-Related Validity

Although the substance scales clearly measure substance abuse, evidence of association between the scales and other measures of problem behavior could not be located.

Evidence of Appropriateness for Different Groups

In a few instances (e.g., PCP, LSD, and heroin, using the adolescent form), reliabilities were lower for Mexican Americans and Native Americans than for other groups. However, for the more common substances (i.e., alcohol, marijuana, cocaine), this was not the case. Data imply that the Alcohol, Marijuana, and Inhalant scales are equally reliable for nonminority and Native American youth in grades 4 through 6. The adolescent form of the ADAS is available in a Spanish-language version.

References

- Oetting, E. R., & Beauvais, F. (1990). Adolescent drug use: Findings of national and local surveys. *Journal of Consulting and Clinical Psychology*, 58(4), 385–394.
- Oetting, E. R., Edwards, R., & Beauvais, F. (1985). Reliability and discriminant validity of the children’s drug-use survey. *Psychological Reports*, 56, 751–756.

Substance Abuse:

Measure 49

Title:

**What About You (WAY),
Forms C and E**

Authors:

Gary D. Gottfredson and Denise C. Gottfredson

Ages: 9–10 (Form E)
11–18 (Form C)

Scales: Ever Variety Drug Use
Last Year Variety Drug Use
Last Month Frequency Drug Use

How To Obtain	Contact Dr. Gary D. Gottfredson, Gottfredson Associates, Inc., 3239B Corporate Court, Ellicott City, MD 21041. Phone: (410) 461-5530.
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Cost	Permission must be obtained to use the WAY questionnaire. Assessment booklets, which are reusable for Form C, cost \$.85 to \$1.00 apiece, depending on the quantity ordered. Answer sheets cost \$.08 or \$.09 each. Scoring costs vary depending on the form and the quantity. Form C answer sheets are scanned and scored for \$.25 each. Form E booklets are keyboarded and scored for \$1.45 each.
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Ages	WAY (Form E) is intended for youth in grades 4 and 5. WAY (Form C) is intended for youth in grades 6 through 12.
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Content	WAY is available in two versions: a 184-item Form C and a 114-item Form E. It contains measures of substance abuse, demographics, and several domains of risk and protection: community, family, school, peer, and individual. Both forms contain a Last Month Frequency Drug Use scale and a Last Year Variety Drug Use scale. Form C also contains an Ever Variety Drug Use scale. The number of items in each scale and sample items are as follows:
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Form C:

Ever Variety—6 items, e.g., “Have you ever smoked marijuana?”

Last Year Variety—14 items, e.g., “In the last year, have you taken amphetamines?”

Last Month Frequency—6 items, e.g., “In the last month, how often have you used cocaine?”

Form E:

Last Year Variety—4 items, e.g., “In the last year have you smoked cigarettes?”

Last Month Frequency—3 items, e.g., “In the last month, how often have you drunk alcoholic beverages?”

Time and Special Arrangements	Administration instructions are provided, along with survey booklets and optically scannable answer sheets. A scoring service is available. The entire WAY survey takes 50 minutes to complete.
Evidence of Reliability	Gottfredson & Gottfredson, (1992b) reported Form C alpha coefficients of .68, .80, and .82 for Ever Variety Drug Use, Last Year Variety Drug Use, and Last Month Frequency of Drug Use scales, and 1-year retest reliability coefficients of .30 and .47 for the last-month and last-year measures, respectively. Alpha coefficients for Form E Last Year Variety Drug Use and Last Month Frequency Drug Use for a general population of children were .55 and .64. Higher reliability (.68) was reported for the Last Year Variety Drug Use scale when used with a more delinquent population.
Evidence of Criterion-Related Validity	Gottfredson and Gottfredson (1992a) provided extensive evidence of validity. For example, the three measures of drug use (using Form C) correlated .31 to .47 with a measure of Rebellious Behavior. Correlations between Rebellious Behavior and Form E Last Year Variety Drug Use and Last Month Frequency Drug Use were .42 and .17, respectively.
Evidence of Appropriateness for Different Groups	<p>Reliability estimates for the Form C scales for African-American males and females and White males and females were similar with a few exceptions (Gottfredson and Gottfredson, 1992a). For the Last Year Variety Drug Use scale, African-American females' coefficients were somewhat lower (.62 versus .76, .83, and .84) than for other groups. Similarly, retest correlations appeared higher for Whites (.63, .44) than for African Americans (.28, .28). Gottfredson and Koper (1997) showed that despite these differences, validity coefficients relating the substance abuse scales to school nonattendance were similar across groups.</p> <p>Gottfredson and Gottfredson (1992a) reported correlations between the three Form C substance abuse scales and a measure of Rebellious Behavior that were similar for boys and girls. Correlations of the Last Month and Last Year substance involvement scales with measures from school records of disciplinary referrals, absences, and grade point average were in the expected direction for all groups but were somewhat lower for African-American males.</p>
References	<p>Gottfredson, D. C., & Koper, C. S. (1997). Race and sex differences in the measurement of risk for drug use. <i>Journal of Quantitative Criminology</i>, 13, 325–347.</p> <p>Gottfredson, G. D., & Gottfredson, D. C. (1992a). <i>Development and applications of theoretical measures for evaluating drug and delinquency prevention programs</i>. Paper presented at the annual meeting of the American Society of Criminology, New Orleans.(*)</p> <p>Gottfredson, G. D., & Gottfredson, D. C. (1992b). <i>What About You Forms C and E, research editions: Supplementary information</i>. Ellicott City, MD: Gottfredson Associates, Inc.(*)</p>

Delinquent or Criminal Behavior:

Measure 50

Title:

National Youth Survey (NYS)

Author:

Delbert S. Elliott

Ages: 11 and older

Scales: General Delinquency
Offense-Specific
Delinquent and
Criminal Behavior

How To Obtain

Contact Dr. Delbert Elliott, Institute of Behavioral Science, University of Colorado, Campus Box 483, Boulder, CO 80309. Phone: (303) 492-1266.

Cost Information on cost can be obtained from the author.

Ages The NYS was developed for use with persons aged 11 to adult.

Content The NYS is an interview used in a national longitudinal study examining delinquency, substance abuse involvement, demographics, and several domains of risk and protection: community, family, work, school, peer, and individual behaviors and attitudes related to delinquency and substance abuse among U.S. youth. It measures several of the factors related to substance abuse covered in this guide. The scales measuring delinquency and criminal behavior are discussed here. The number of delinquency items changes slightly with each edition of the NYS. Some offenses (e.g., status offenses) are dropped and others (e.g., credit card fraud) are added as the sample ages. The survey contains approximately 35 self-report delinquency items that can be scored to provide a General Delinquency scale or shorter homogeneous offense-specific scales (Felony Assault, Minor Assault, Robbery, Felony, Theft, Minor Theft, and Vandalism). Respondents indicate the number of times ("never," "once or twice," or "once every 2–3 months") they have committed each act in the past year. If the act was committed 10 or more times, an expanded frequency question is also asked; response categories range from "once a month" to "2–3 times a day." Items include "Carried a hidden weapon other than a plain pocket knife," "Hit (or threatened to hit) one of your parents," and "Had (or tried to have) sexual relations with someone against their will."

Time and Special Arrangements

Instructions for administration and reporting are available from the author.

Evidence of Reliability

Huizinga and Elliott (1986) reported a 4-week retest correlation of .75 for the General Delinquency scale measuring the *frequency* of delinquent acts and .84 for a General Delinquency scale measuring the *variety* of different delinquent acts reported.

**Evidence of
Criterion-Related
Validity**

Elliott, Huizinga, and Menard, (1989) reported extensive analyses that suggested that the self-report delinquency measures are valid measures of delinquency. For example, approximately 80 percent of official arrest records were matched with self-reported offenses. Also, self-reports of criminal behavior had correlations of .33 and .35 with self-reports of marijuana and multiple illicit substance abuse in a national sample of youth aged 11 to 17 years.

**Evidence of
Appropriateness for
Different Groups**

Huizinga and Elliott examined retest correlations separately for Whites and African Americans and found no systematic differences in reliability. The validity of self-reports appeared similar for males and females, but more underreporting of offenses was observed for African Americans than for Whites.

References

Elliott, D. S., Huizinga, D., & Menard, S. (1989). *Multiple problem youth: Delinquency, substance use, and mental health problems*. New York: Springer-Verlag.

Huizinga, D., & Elliott, D. S. (1986). Reassessing the reliability and validity of self-report delinquency measures. *Journal of Quantitative Criminology*, 2(4), 293–327.

Delinquent or Criminal Behavior:

Measure 51

Title:

Monitoring the Future (MTF)

Ages: grades 8–college and
young adult

Scale: Total Delinquency

Authors:

Lloyd D. Johnston, Jerald G. Bachman, and Patrick O'Malley

How To Obtain

Contact Dr. Lloyd D. Johnston, Institute for Social Research, University of Michigan, Ann Arbor, MI 48106. Phone: (313) 763-5043. The forms for the 8th and 10th grade surveys are available on the World Wide Web at www.icpsr.umich.edu/SAMHSA/mtf.html

Cost

Single copies can be obtained at no cost; the instruments are in the public domain. No services are provided by the authors, and multiple copies of the forms are not available for use.

Ages

The Monitoring the Future survey is available for use with students in grades 8 through 12, and also for college students and young adults.

Content

The MTF survey is a self-report questionnaire available in several different forms, each containing different sets of items and designed for different age groups. Six forms are available for use with college students and young adults, six for students in grade 12, and two for students in grades 8 and 10. Users are encouraged to choose those questions most appropriate to their work. Many variables are common to more than one form, and many (e.g., substance abuse measures) appear on all forms for a given grade level. Each form contains 300 to 350 variables measured by approximately 100 questions on approximately 12 pages. Each form measures substance abuse, demographic characteristics, and risk and protective factors in the following domains: community (e.g., substance availability), school, peer, and individual. The Total Delinquency scale contains 16 items representing a variety of delinquent acts. Respondents indicate how often they have committed the act in the past 12 months. Responses range from "5 or more times" to "not at all." Items include "Damaged school property on purpose" and "Taken something that did not belong to you worth under \$50."

Time and Special Arrangements

Each Monitoring the Future form is designed to be administered in a single class period (45–50 minutes). The survey is printed on an optically scannable form.

Evidence of Reliability

Bachman (1975) reported (for an earlier version of the Total Delinquency scale) a 1-year retest coefficient of .63, 18-month retest coefficient of .53, and a 22-year retest coefficient of .48.

**Evidence of
Criterion-Related
Validity**

Concurrent correlations between a Rebellious Behavior in School scale and an earlier version of the Total Delinquency scale were .53 and .64.

**Evidence of
Appropriateness for
Different Groups**

The research reported above was based on a national sample of White males. In a large sample of African Americans from two urban schools, Gottfredson (1987) reported an alpha of .86 for the earlier version of the Total Delinquency scale. In the same study, evidence of validity was demonstrated when the scores on the scale were responsive to an intervention aimed at reducing delinquency.

References

- Bachman, J. G. (1975). *Youth in transition: Documentation manual* (Vol. II, 2nd ICPSR ed.). Ann Arbor, MI: Inter-University Consortium for Political and Social Research.
- Gottfredson, D. C. (1987). An evaluation of an organization development approach to reducing school disorder. *Evaluation Review*, 11(6), 739–763.

Delinquent or Criminal Behavior:

Measure 52

Ages: 11–18

Title:

Scale: Antisocial Behavior

Communities That Care Youth Survey

Authors:

Michael Arthur, John A. Pollard, J. David Hawkins, and
Richard F. Catalano

How To Obtain

Contact Customer Service, Developmental Research and Programs, Inc., 130 Nickerson St., #107, Seattle, WA 98119. Phone: (206) 286-1805, Fax: (206) 286-1462.

Cost Cost is \$1.80 per survey form. There are additional costs (\$300–\$625) for analysis and report generation. The survey can be customized to better meet individual user's needs for an additional fee.

Ages The survey instrument has been used with youth aged 11 through 18 (grades 6–12).

Content The Communities That Care Youth Survey contains 201 items. It includes scales measuring substance abuse; demographic characteristics; and community, family, school, peer, and individual factors related to substance abuse. The Antisocial Behavior scale is made up of eight items and consists of such questions as "How many times in the past year (12 months) have you . . . been suspended from school? Carried a handgun? Sold illegal drugs?" Response categories range from "never" to "40+ times."

Time and Special Arrangements The survey instrument is designed to be administered in a single class period of 45 minutes to 1 hour. Administration instructions are provided by Developmental Research and Programs, Inc. (DRP). The survey is provided on an optically scannable form. Completed surveys are returned to DRP for scoring, development of the data base, analysis, and report generation. The survey organizer is responsible for administration and return of the completed surveys to DRP.

Evidence of Reliability The authors reported a Cronbach's alpha of .93 for the Antisocial Behavior scale.

**Evidence of
Criterion-Related
Validity**

The Antisocial Behavior scale had correlations ranging from .20 to .32 with various measures of substance abuse.

**Evidence of
Appropriateness for
Different Groups**

The data presented above were from a predominantly White adolescent population. Survey appropriateness has not been assessed for other specific ethnic or racial populations.

References

This is a newly developed instrument, and a manual or other source document is not yet available. Contact John Pollard with questions at (206) 286-1805.

Sexual Activity:

Measure 53

Ages: 14–18

Title:

Scale: N/A

Scale of AIDS Risk (SAR)

Authors:

Carol Metzler, John Noell, and Anthony Biglan

How To Obtain	The items are listed in Metzler, Noell, and Biglan (1992), but permission should be obtained from the authors before using. Contact Carol Metzler, Oregon Research Institute, 1899 Willamette St., Eugene, OR 97401.
Cost	For use and cost of use, contact Carol Metzler, Oregon Research Institute, 1899 Willamette St., Eugene, OR 97401.
Ages	The SAR has been used with samples of youth ranging from 14 to 18 years of age.
Content	Six items make up the SAR. Sample items include “Altogether during the past year, how many different people of the opposite sex have you had as sexual partners?” and “When you have sexual intercourse, how often do you or your partner(s) wear a condom?”
Time and Special Arrangements	The SAR should take only a few minutes to complete because it consists of only six items.
Evidence of Reliability	Cronbach’s alphas of .63, .75, and .81 have been obtained using three different samples.
Evidence of Criterion-Related Validity	Correlations between the SAR and measures of substance abuse ranged from .23 to .52, depending on the substance and the specific adolescent sample. The SAR is also correlated .4 to .5 with a measure of antisocial behavior.
Evidence of Appropriateness for Different Groups	Psychometric evidence was not presented separately for males and females. And, since the samples used in the validation studies were 90 percent White, it is unknown whether the SAR is equally reliable and valid for different ethnic groups.

- References** Biglan, A., Metzler, C. W., Wirt, R., Ary, D., Noell, J., Ochs, L., French, C., & Hood, D. (1990). Social and behavioral factors associated with high-risk sexual behavior among adolescents. *Journal of Behavioral Medicine*, 13(3), 245–261.(*)
- Metzler, C. W., Noell, J., and Biglan, A. (1992). The validation of a construct of high-risk sexual behavior in heterosexual adolescents. *Journal of Adolescent Research*, 7(2), 233–249.(*)

Sexual Activity:

Measure 54

Ages: 12–18

Title:

Scale: Sexuality

Life Events Questionnaire (LEQ)

Authors:

Michael D. Newcomb, George J. Huba, and Peter M. Bentler

How To Obtain

Contact Michael D. Newcomb, 722 Kensington Road, Santa Monica, CA 90405-2420. Phone: (310) 825-5735.

Cost

Availability and price information can be obtained from address listed above.

Ages

The LEQ was developed using data from adolescents in grades 10–12 (ages 15–18) and has been used with adolescents aged 12–18.

Content

The LEQ is a self-report checklist of life events. Respondent indicates only whether the event has or has not occurred during a specified period. The Sexuality scale contains seven items; examples of these are “Lost virginity,” “Got or gave venereal disease,” and “Got or made pregnant.”

Time and Special Arrangements

The LEQ is a written self-report and can be administered to adolescents individually or in groups.

Evidence of Reliability

Information on the development, reliability, and validity of the instrument was presented in the source document (Newcomb, Huba, & Bentler, 1981) and a later article by the same authors (Newcomb, Huba, & Bentler, 1986). The KR-20 coefficient was .50 for the Sexuality scale for a large sample of high school students. A reliability coefficient (form of reliability coefficient was not reported) of .57 for the Sexuality scale was reported for a sample of 12- to 18-year-old adolescents.

Evidence of Criterion-Related Validity

Correlations between the Life Events scales and measures of substance abuse were reported for the two samples mentioned above. Significant correlations were found between the Sexuality scale and abuse of beer, wine, liquor, marijuana, and cocaine.

Evidence of Appropriateness for Different Groups

The LEQ was developed using a sample of adolescents that included Latino, African-American, Asian, and European-American youth. Means, but no reliability or validity evidence, were reported separately by grade and ethnic group in the source document. KR-20 coefficients were reported separately by sex; they were slightly higher for males on the Sexuality scale.

- References** Newcomb, M. D., Huba, G. J., & Bentler, P. M. (1981). A multidimensional assessment of stressful life events among adolescents: Derivation and correlates. *Journal of Health and Social Behavior*, 22, 400–415.
- Newcomb, M. D., Huba, G. J., & Bentler, P. M. (1986). Life change events among adolescents: An empirical consideration of some methodological issues. *Journal of Nervous and Mental Disease*, 174, 280–289.

Sexual Activity:

Measure 55

Title:

Sexual Risk

Ages: older adolescent, adult

Scale: Seven-Point Assessment
of Sexual Risk

Authors:

H. Virginia McCoy and James A. Inciardi

How To Obtain

The sexual risk measure is reproduced in McCoy & Inciardi, 1993.

Cost

Contact the authors.

Ages

The seven-point assessment of sexual risk has been used with adults but could also be used with older adolescents.

Content

A seven-point scale ranks safe to unsafe sexual activities: 0 = no sex (no risk), 1 = vaginal sex with condom, 2 = vaginal and oral sex with a condom, 3 = vaginal sex without a condom, 4 = vaginal and oral sex without a condom, 5 = anal sex with a condom, and 6 = anal sex without a condom. Responses to questions are in a yes/no format and include items such as "Have you ever had sexual intercourse?" and "Have you ever had vaginal or oral sex without a condom?" (McCoy & Inciardi, 1993).

Time and Special Arrangements

Because of the sensitive nature of these questions, care should be taken to protect the identity of the respondents.

Evidence of Reliability

Reliability evidence for this Guttman-type scale is not reported in the source document.

Evidence of Criterion-Related Validity

Using a sample of females, current crack cocaine use was correlated .22 with the seven-point measure of sexual risk.

Evidence of Appropriateness for Different Groups

Reliability and validity evidence for different ethnic or gender groups was not reported.

References

McCoy, H. V., & Inciardi, J. A. (1993). Women and AIDS: Social determinants of sex-related activities. *Women & Health, 20*(1), 69-86.

Withdrawal From School:

Measure 56

Ages: grades 9–12

Title:

Scale: N/A

School Records of Truancy and Dropout

Author:

N/A

How To Obtain	N/A
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Cost	N/A
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Ages	School attendance records show meaningful interindividual variability from early grades. There is usually little dropping out recorded in official school system records before grade 9 or 10. Some education agencies maintain that there is no dropping out before certain ages (because dropping out is technically forbidden by statute) and do not record dropping out. In some locations, however, substantial dropout occurs before high school: A District of Columbia study found that 56 percent of public school dropouts left school before grade 10 (Tuck, 1988).
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Content	These problem behaviors can be measured by using school records of withdrawal from school and absenteeism. Different school systems record attendance and withdrawal information in different ways. Some use paper records and others computerize this information. Because of district accountability programs and school financing arrangements, evaluators can be virtually certain that information of this kind is maintained by schools and is therefore available provided that access can be arranged. Student records are generally maintained at each school site and are also often available centrally through the school district. It is not always possible through the use of school records to distinguish dropping out from other forms of school withdrawal (e.g., a geographical relocation). School records vary in quality from location to location, and the dependability of information should be investigated by users.
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Time and Special Arrangements	N/A
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Evidence of Reliability	Gottfredson and Gottfredson (1992) reported 1-year retest reliability for school absences ranging from .63 to .73 for different sex and ethnic groups of middle school students.
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**Evidence of
Criterion-Related
Validity**

Snowden and Peel (1985) identified dropping out, expulsion, and suspension for students in 14 Arkansas school systems and reported data showing more substance abuse than a comparison sample of high school students in another Southern State. Cardenas (1988) obtained dropout data from the education records of the 254 counties in Texas. Gottfredson and Gottfredson extracted absence data from an urban school district's records and reported the following correlations with a last-year variety substance abuse measure: .05 (Black males, not significant), .12 (White males), .17 (Black females), and .14 (White females).

**Evidence of
Appropriateness for
Different Groups**

Dropout rates are higher for African-American and Latino youths than for other groups of students (e.g., Cardenas, 1988). At least for African-American and White students, the correlates of dropout are substantially similar, however (Gottfredson, 1981). Gottfredson and Gottfredson reported somewhat lower retest reliabilities and lower correlations with substance abuse for African-American than for White middle school students. More evidence about absences and substance abuse for different groups would be helpful.

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Withdrawal From School:

Measure 57

Ages: 9–young adult

Title:

Scale: N/A

Self-Report Items Measuring Dropout and Truancy From School

Authors:

Various authors (see reference list below)

How To Obtain	The items are listed below and can be found in the references.
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Cost	Costs of local duplication and scoring.
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Ages	Questions like these may be asked of students as young as 9 years old. The Halikas and Rimmer questions were asked of young adults.
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Content	Many studies have asked youth to self-report withdrawal from school. Below are some examples.
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Swadi (1989) asked students, “How often have you [skipped school]?” Response categories were “never,” “less than 10 times,” “on average once a week,” and “on average more than once every week.”

Pritchard, Diamond, Fielding, Cox, Choudry, (1987) asked youths, “Have you in this school year [skipped school]?”; “Have you done this in the last week?”; “If not, in the last month?”; and “Have you done this more than 3 or 4 times?” Yes/no responses are used for each question. In the Pritchard et al. usage, *truants* are those who have reported skipping school in the last term and others are *nontruants*; *frequent truants* are those who have skipped school more than three or four times.

Halikas and Rimmer (1974) asked adults (mean age 22), “Have you ever been suspended or expelled from school?”; “Have you ever dropped out of school?”; and “Were you ever truant prior to your last year in school?”

Time and Special Arrangements	None.
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Evidence of Reliability	Reliability information was not reported for any of the single-item indicators.
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Evidence of Criterion-Related Validity	<p>Defining truant youth as those who skip school on average once a week or more, Swadi (1989) reported that truant males and females were significantly more likely to smoke daily than nontruants. Pritchard et al. (1987) found that truants were significantly more likely than nontruants to misuse substances, use solvents, fight, and engage in vandalism. Halikas and Rimmer (1974) found that polysubstance abusers were significantly more likely than moderate users to have ever been suspended or expelled, ever dropped out of school, and ever been truant prior to their last year in school.</p>
Evidence of Appropriateness for Different Groups	<p>Swadi found the relationship between truancy status and having ever used a variety of substances was greater for males than for females. However, use of alcohol more than once a week was significantly related to truancy for females but not males. Although reliability and validity evidence was not reported by ethnicity, this item has been used with European Americans and roughly equal numbers of Asian and West Indian youths.</p>
References	<p>Halikas, J. A., & Rimmer, J. D. (1974). Predictors of multiple drug abuse. <i>Archives of General Psychiatry</i>, 31, 414–418.</p> <p>Pritchard, C., Diamond, I., Fielding, M., Cox, M., & Choudry, N. (1987). Drug misuse and truancy in normal 4th and 5th year comprehensive schoolchildren. <i>Maladjustment and Therapeutic Education</i>, 5(3), 2–16.</p> <p>Swadi, H. (1989). Adolescent substance use and truancy: Exploring the link. <i>European Journal of Psychiatry</i>, 3(2), 108–115.</p>

Appendix A

Directories of Measurement Instruments Relevant to Substance Abuse Prevention Program Evaluation

Source	Description
Substance Abuse	
Center for Substance Abuse Prevention. (1993). <i>Maternal substance use assessment methods reference manual: A review of screening and clinical assessment instruments for examining maternal use of alcohol, tobacco, and other drugs</i> (CSAP Special Report 13. DHHS Publication No. SMA93-2059). Rockville, MD: Author.	This manual reviews 39 instruments, some of which were developed specifically for pregnant women. The 22 screening instruments provide measures of alcohol, tobacco, and drug use/abuse; and the 17 clinical assessment instruments examine personal and psychosocial issues often related to substance use/abuse.
Gottfredson, D. C., Fink, C. M., Harmon, M. A., Lopes, J. A., Stanley, D. L., & Gottfredson, G. D. (1993). <i>Compendium of instruments to measure drug use and risk factors for drug use</i> . Unpublished Manuscript, University of Maryland, College Park.	Summarizes 66 measures of substance abuse and research-based risk and protective factors: antisocial behavior; academic failure; commitment, attachment, and belief; association with delinquent, drug-using peers; attitudes favoring use; social competency; family management practices; drug availability; rules and sanctions; and social disorganization.
IOX Assessment Associates. (1988). <i>Drug abuse education. Program evaluation handbook</i> . Los Angeles: the Associates.	A resource book for evaluators of drug abuse education programs. Handbook includes 22 measures of behavior, knowledge, skill, and affective outcomes thought to be the most likely outcomes sought in drug abuse prevention programs.
Kumpfer, K. L., Shur, G. H., Ross, J. G., Bunnell, K. K., Librett, J. J., & Millward, A. R. (1993). <i>Measurements in prevention: A manual on selecting and using instruments to evaluate prevention programs</i> . (CSAP Technical Report 8 DHHS Publication No. ADM 93-2041). Washington, DC: Center for Substance Abuse Prevention.	A compendium of over 200 instruments for assessing the effectiveness of substance abuse prevention strategies directed at various risk factors. This manual includes an extensive list of instruments that have been used in prevention or research studies to measure many different outcome variables, organized by locus of intervention: individual, peer, family, school, and community.

Source	Description
Linney, J. A., & Wandersman, A. (1991). <i>Prevention Plus III: Assessing alcohol and other drug prevention programs at the school and community level. A four-step guide to useful program assessment.</i> (DHHS Publication No. ADM 91-1817). Washington, DC: Office for Substance Abuse Prevention.	A practical guide for conducting process and outcome evaluation for substance abuse prevention programs. Contains 40 instruments to measure program processes and outcomes, including satisfaction with the program; alcohol, tobacco, and drug awareness, attitudes, and knowledge; substance abuse; youth outcomes such as problem-solving skills, coping skills, locus of control, self-esteem, and alternative activities; family and parent outcomes such as parenting skills, family functioning, and sense of satisfaction; and school and community factors such as classroom environment, sense of community, and community services.
McLellan, T., and Dembo, R. (1993). <i>Screening and assessment of alcohol- and other drug-abusing adolescents</i> (Treatment Improvement Protocol [TIP] Series 3, DHHS Publication No. SMA 93-2009). Rockville, MD: Center for Substance Abuse Treatment.	Appendix A of this document describes 41 instruments designed for adolescents. Instruments measure alcohol, tobacco, and other drug use/abuse; physical health; school status and problems; peer relations; problem behavior (including delinquency, aggression, and high-risk sexual behavior); family relationships; and psychological health.
Nehemkis, A., Macari, M. A., & Lettieri, D. J. (Eds.). (1976). <i>Drug abuse instrument handbook: Selected items for psychosocial drug research.</i> (National Institute of Drug Abuse, Research Issues Series 12). Washington, DC: U.S. Government Printing Office (Stock No. 017-024-00533-9).	A basic reference tool identifying existing instruments and suggested items for the creation of new instruments. More than 2,000 items from 40 instruments are included, categorized according to the areas they assess. Instruments were selected for inclusion if they discriminated between drug users and nonusers or identified different drug user types. Items are categorized according to demographic, interpersonal, intrapersonal, and drug variables.
General	
Buros Institute of Mental Measurements. (1983). <i>Tests in Print III: An Index to Tests, Test Reviews, and the Literature on Specific Tests.</i> J.V. Mitchell, Jr. (Ed.). Lincoln, NE: Buros Institute of Mental Measurements, University of Nebraska–Lincoln.	<i>Tests in Print III</i> is the third in a series and contains 2,672 test entries. Each entry consists of a very short writeup that describes the instrument and lists related references. The number of test entries under each of the following categories ranges from 24 (neuropsychological) to 576 (personality) and includes achievement, development, intelligence and scholastic aptitude, sensory-motor, and vocations, among others.
Buros Institute of Mental Measurements. (1992). <i>The eleventh mental measurements yearbook.</i> J. J. Kramer and J. C. Conoley, (Eds.). Lincoln, NE: Buros Institute of Mental Measurements, University of Nebraska–Lincoln.	Criteria for inclusion in the 11th yearbook are that the test be new or revised since the <i>Tenth Mental Measurement Yearbook</i> published in 1989. This work includes information (title, purpose, age group, publication date, scales, administration, price, administration time, author, and publisher) on 477 commercially available tests and 703 test reviews (many instruments have more than one written review). Among the 18 major classifications are personality, vocations, development, education, achievement, behavior assessment, sensory-motor, and multiple-aptitude batteries.

Source	Description
Buros Institute of Mental Measurements. (1994). <i>Supplement to the eleventh mental measurements yearbook</i> . J. C. Conoley, and J. C. Impara (Eds.). Lincoln, NE: Buros Institute of Mental Measurements, University of Nebraska–Lincoln.	This supplement is only the third supplement of the <i>Mental Measurements Yearbook</i> series. It contains reviews of 101 new or significantly revised instruments since publication of the <i>Eleventh Mental Measurements Yearbook</i> . The same classification categories and types of information are provided in the supplement as in the regular series.
Corcoran, K., & Fischer, J. (1987). <i>Measures for clinical practice: A sourcebook</i> . New York: Free Press.	Divided into three sections (instruments for adults, children, and couples), this sourcebook reviews and provides a copy of 127 instruments. Areas measured include alcoholism, anger, anxiety, assertiveness, various beliefs, depression, family functioning, health issues, hostility, interpersonal behavior, parent-child issues, self-concept, self-control, self-efficacy, social support, and others.
Goldman, B. A. (Ed.) Osborne, W. L., & Mitchell, D. F. (1990). <i>Directory of unpublished experimental mental measures</i> (Vols. 4–5). Washington, DC: American Psychological Association.	The fifth volume in a five-volume series (as of this writing) publishes descriptions of measures not available commercially. The measures can be found in 37 professional journals and are grouped in 24 categories such as psychological, educational, social, and vocational achievement; aptitude; behavior; communication; development; family; motivation; problem solving and reasoning; and values (moral, philosophical, political, and religious).
Grotevant, H. D., & Carlson, C. I. (1989). <i>Family assessment: A guide to methods and measures</i> . New York: Guilford Press.	A basic reference tool for family assessment measures. Measures are reviewed, discussed, and compared. Includes measures of family functioning, family stress and coping, and parent-child relations.
Keyser, D. J., & Sweetland, R. C. (Eds.). (1984). <i>Test critiques</i> (Vols. I–X). Kansas City, MO: Test Corporation of America.	Each volume provides approximately 100 test critiques listed alphabetically. Beginning in volume III, a cumulative subject index is included corresponding with the classification system used in <i>Tests: A Comprehensive Reference for Assessments in Psychology, Education, and Business</i> . Each critique includes an introduction (test development, structure, scoring), practical applications/uses, technical applications (reliability, validity), and critique (overall review with pros and cons).
Miller, D. C. (1991). <i>Handbook of research design and social measurement</i> . (5th ed.). Newbury Park, CA: Sage.	This research handbook includes an extensive section on scales and indexes commonly used in social research. Instruments are summarized in the following areas: social status, group structure and dynamics, social indicators, organizational structure, community, social participation, leadership in the work organization, morale and job satisfaction, attitudes, values and norms, family and marriage, and personality. Forty-nine instruments are included.

Source	Description
Robinson, J. P., Shaver, P. R., & Wrightsman, L. S. (Eds.). (1991). <i>Measures of personality and social psychological attitudes</i> . San Diego: Academic Press.	A basic reference for measurement of attitudes. Provides a comprehensive guide to many promising and useful measures in 11 broad areas: subjective well-being, self-esteem, social anxiety, shyness and related constructs, depression and loneliness, alienation and anomie, interpersonal trust and attitudes toward human nature, locus of control, authoritarianism and related constructs, sex roles, and values. Ten to 20 promising instruments are reviewed in each area.
Sweetland, R. C., Keyser, D. J., & O'Connor, W. A. (Eds.). (1983). <i>Tests: A comprehensive reference for assessments in psychology, education, and business</i> . Kansas City, MO: Test Corporation of America.	<i>Tests</i> provides a very short description of over 3,000 instruments covering areas such as child development, intelligence, marriage, family, and personality in the psychology section and academic subjects, achievement and aptitude, educational development and preschool readiness, special education, and sensory motor skills in the education section.
Sweetland, R. C., & Keyser, D. J. (Eds.). (1984). <i>Tests: A comprehensive reference for assessments in psychology, education, and business. Supplement</i> . Kansas City, MO: Test Corporation of America.	This reference is a supplement to <i>Tests</i> (described above) and contains a short description of 500 additional instruments, some of which are new and others that were not included in the primary book.
Touliatos, J., Perlmutter, B. F., & Straus, M. A. (Eds.). (1990). <i>Handbook of family measurement techniques</i> . Newbury Park, CA: Sage.	Contains 976 abstracts of instruments organized into five areas: interaction, intimacy and family values, parenthood, roles and power, and adjustment. Unpublished instruments described in the handbook have been placed in the National Auxiliary Publications Service.
Weiss, H. B., & Jacobs, F. H. (Eds.). (1988). <i>Evaluating family programs</i> . New York: A. de Gruyter.	Lists 86 instruments for assessment of family-related programs. Instruments include (1) infant and child intelligence, development, and behavior scales; (2) child, adolescent, and parent assessments of parent-child interactions and general family functioning; (3) social support and stress questionnaires; and (4) family and classroom observation measures.

Appendix B

Glossary of Technical Terms

Many of the terms used in this guide have technical meanings that may not be easily interpreted. This glossary provides simple definitions of some of these terms. Further clarification on the meaning of many of these terms can be found elsewhere (Bartko, 1976; Linn, 1993; Wainer & Braun, 1988).

Aggregated information. Information on individuals can be aggregated into summaries to describe groups. For example, levels of delinquency can be averaged (aggregated) for classroom, school, neighborhood, or community. One source of information to describe any community's level of risk is data pertaining to individuals aggregated to higher levels to describe those levels. Often, it is useful to disaggregate information that is usually available only for composites, masking important differences in levels of risk for different groups (e.g., boys and girls, members of different ethnic groups, persons with different family income levels).

Alpha. A way of estimating the degree of internal consistency among a set of items in an instrument (see *reliability*, *internal consistency*).

Archival record. Information stored or archived in the course of an organization's activity, which can often be assembled in ways useful for needs assessment or evaluation. Examples include school transcripts or records, emergency-room admissions information, or arrest records.

Concurrent correlation. A correlation or statistical association between two measurements obtained at the same time.

Construct validation. The process of determining whether a measure or set of measures produces empirical evidence consistent with a theory. Many kinds of evidence are relevant in the construct validation of an assessment procedure, and the evidence produced by research can undermine or support both a theory and the measures presumed to represent its constructs. For instance, information produced using a measurement method may be said to show evidence of construct validity when (1) it is used as an indicator of a construct, (2) there is a theoretical understanding of the construct that the indicator is said to measure, and (3) empirical evidence shows that the indicator behaves as expected by the theory.

Content validity. The extent to which the item content of a composite index or test represents the broader factor of interest. For example, an index of drug involvement that omitted an assessment of some of the more commonly abused substances such as tobacco, marijuana, and alcohol could be said to show low content validity. Content validity is sometimes invoked as the primary evidence of validity when there is scant evidence of a more persuasive kind about the validity of inference made for the instrument (see *validity*). In other cases judgments of content validity may be useful (e.g., when one demonstrates that the items in a test match the content of instruction).

Convergent and discriminant validity. A kind of evidence about the validity of inference made for a test or other measuring device (see *validity*). An instrument is said to show convergent validity when scores or numbers derived from its application converge with the scores or num-

bers derived from other measuring devices expected to measure the same *construct* (e.g., risk factors, causal variable, outcome). An instrument is said to show discriminant validity when scores or numbers derived from its application show independence of the scores or numbers derived from the application of other measuring devices expected to measure other constructs or irrelevant sources of contamination.

Effect size. Any of several statistics used to summarize the strength of association between two variables. The term *effect* originates in experimental research in which an independent variable is manipulated by the experimenter and the effect size statistic summarizes the extent to which the dependent variable is associated with the manipulated causal variable. In nonexperimental research, *effect size* measures summarize the degree of association between two variables and do not necessarily imply cause-and-effect relations between the two.

Experimental validation. The process of determining whether the scores produced by the application of a measuring device change as expected in response to attempts to change them by means of theoretically relevant intervention (see *validity, construct validation*).

Face validity. The extent to which a measurement device appears plausible to those who examine its content. Despite its name, this is not a form of validity evidence (see *validity*). It is nevertheless important because decisionmakers and the public are likely to reject the use of measures they do not regard as plausible. Face validity has practical value in some circumstances but has no scientific meaning beyond this practical value.

Homogeneity coefficient. A number summarizing information about internal consistency of a measuring instrument (see *reliability, internal consistency*).

Instrument. A collection of items, a test, or battery of tests used in a reasonably standardized way to collect information.

Internal consistency. A way of estimating reliability (see *reliability*) that ignores change over time as a source of error in measurement. Measures with high internal consistency may be said to measure whatever they measure with relatively little error at a point in time, that is, on the occasion of measurement. A test or scale with low internal consistency may be said to not be measuring anything particularly well. *KR20*, *KR21*, *corrected split-half*, *alpha*, and *Hoyt* coefficients are all alternative ways of computing an internal consistency estimate.

Interrater reliability. An index of the extent to which different observers agree in assigning scores to an entity, person, behavior, or phenomenon. Interrater reliability estimates treat disagreement between observers as error.

Intraclass correlation (ICC). An approach to assessing agreement among raters, for ratings of persons, families, or neighborhoods, for example. It is based on a decomposition of sources of variance in ratings. ICC is high when there is little disagreement among raters relative to the degree of variability among objects rated. The reliability of composite scores for an environment or other object of measurement when multiple raters are used, called a “stepped-up” ICC, is an appropriate index of reliability for measures that depend upon multiple informants. See Bartko (1976).

Item. One of the component parts of a test, scale, or index: a separately scorable element of a test or scale. Information from items is combined with information from other items to produce a score on a test, scale, or index.

Kappa. An index of agreement for nominal measurement. Kappa is the ratio of greater-than-chance agreement observed to greater-than-chance possible for two independent sets of classified observations. It can be interpreted as a proportion. Values range from 0 to 1.0. For a two-by-two table, kappa equals phi.

KR20. A way of estimating internal consistency (see *reliability*, *internal consistency*). KR20 is a special case of alpha that can be computed only if all of the items contributing to a composite index take on only one of two values (e.g., T or F, 0 or 1, Yes or No, Right or Wrong).

KR21. A shortcut method of estimating the *internal consistency* of a scale with dichotomously scored items (see *reliability*, *internal consistency*).

Likert-type item. An item making use of response or rating options ordered on a scale with three or more values. Examples: (4) often, (3) sometimes, (2) seldom, (1) never; (1) strongly disagree, (2) disagree, (3) agree, (4) strongly agree. This type of item is named for R. A. Likert, who was an early advocate of measuring attitudes by adding together respondents' item values for several such items to produce a total attitude score for each person.

Nominal measurement. The assignment of scores (e.g., A, B, C or 1, 2, 3) to objects by rules that do not imply an ordering of these scores from low to high. An example of nominal measurement is the five-category classification often used to capture information about ethnicity.

Norms. A basis for comparing information about a person, school, or community with other similar individuals, schools, or communities. Norms are data about the distribution of scores or index values for a reference sample or population. Without knowledge of the extent of marijuana use for a national sample of high school seniors, one would not be able to determine whether a particular high school senior uses more or less marijuana than do typical high school seniors, for example.

Ordinal measurement. The assignment of numbers to entities, behavior, people, or phenomena such that higher numbers are intended to indicate a greater degree of whatever is being measured.

Predictive validity. In common use, the correlation coefficient between a measurement and some criterion (e.g., outcome, behavior) measured at a later time.

Protective factor. A characteristic of individuals, families, schools, or communities that has been shown to be inversely statistically associated with the probability of involvement with drugs. A protective factor may or may not be a causal factor. A second definition of protective factor—a characteristic that mitigates the influence of some other risk factor—defines a process that is not well established by research at this time.

Ratings. Numbers assigned to entities, behavior, people, or phenomena based on the judgments or reports of one or more observers (e.g., self-ratings, teacher ratings, parent ratings, clinician ratings, peer ratings).

Reliability. Freedom from error. In general, the larger the degree of variability in a measurement that is attributable to chance, instability, or random noise in a measure, the lower its reliability. Reliability coefficients are reported as numbers that range from 0.0 (all error) to 1.0 (no error). A reliability coefficient can be expressed as a proportion: the proportion of variance in scores that is not error.

Measurement specialists distinguish several different kinds of *reliability* that differ in what the measurer regards as error. For example, some definitions of reliability regard any unsystematic change over time as error, and other definitions do not regard change over time as a contributor to error. See separate glossary entries for specific kinds of reliability estimates under *alpha interrater*, *KR20*, *retest reliability*, *homogeneity coefficient*, *internal consistency*.

There is no such thing as *the* reliability of an assessment, casual usage by writers notwithstanding. Not only do the numbers that estimate reliability depend on what is defined as *error* or noise, but they also depend on the sample in which reliability is estimated. Reliability estimates will tend to be low (even zero) when measurement is applied to characteristics of individuals or communities that do not differ on the factor being measured. For example, a carefully conducted interview about drug involvement applied to a diverse sample of high school 10th graders may produce a high reliability coefficient (perhaps .80) but have a reliability coefficient of .00 in a sample of 3rd graders none of whom has experimented with any drug.

The degree of reliability in an assessment depends on many things. Among these are the amount of variability in the characteristic being measured in the sample of individuals or units being assessed, the care with which respondents or raters answer questions, respondents' ability to understand the questions or remember events or behaviors accurately, and the care with which information is recorded in archival records or extracted from them.

Resiliency factor. See *protective factor*.

Retest reliability. A way of estimating reliability (see *reliability*) that treats changes over time as meaningful sources of error in measurement. An assessment procedure that produces high retest reliability coefficients will tend to rank order individuals (or schools, neighborhoods, or communities) in the same way over time.

Risk factor. A characteristic of individuals, families, schools, or communities that has been shown to be statistically associated with the probability of involvement with drugs. A risk factor may or may not be a causal factor.

Sample. A subset of a larger set (or population) of individuals or other units. Care in selecting samples for needs assessment and evaluation is required, or the sample may not well represent the larger set or population. Expert advice is often required to draw a representative sample.

Scale. A quantitative index used to assess or describe the degree of a characteristic, trait, or other variable. In common usage, a collection of items each tending to provide an indicator of a common construct.

Self-report measures. Numbers assigned to individuals based on their own responses to one or more questions, whether or not combined into scales. For example, a self-report measure of

impulsivity might be a composite index derived from a number of ratings an individual offers for himself or herself on several specific items.

Survey. A systematic attempt to collect information representative of a group or area. Usually, a survey entails a plan to *sample* a relevant area or group and a standardized *instrument* (or collection of items) specifying the information to be collected for each person or unit.

Validity. An index of the degree to which a decision or interpretation made from an assessment is correct in either an abstract or a concrete sense. Although speakers and writers often casually refer to “validity” as if it were a property of a test, index, or assessment result, the term more properly refers to the *inferences* made on the basis of the assessment. An assessment (or score) that may be a basis for making valid inferences of one kind may provide no information useful in making valid inferences about other matters. For example, a verbal ability test may provide a basis for making moderately correct predictions of a group of persons’ grades in school, but it may provide little basis for estimating physical stamina.

Despite careless use of language, there is no such thing as *the* validity of an index, test, or assessment procedure. But measurement specialists speak of several kinds of evidence useful in judging the validity of alternative inferences made from measures. Among the validity-related terms used are *face validity*, *content validity*, *convergent and discriminant validity*, *predictive validity*, and *experimental validity*. Each of these is given a separate definition in this glossary. Ultimately, the accumulation of various kinds of information about the meaning of assessment results allows measurement specialists to speak of *construct validation*.

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